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TRANSCRIPT

Dr. Boufford Good morning, everyone. We'll have a lot of folks online today. So, we'll start, even though the room is a little thinner, we'll have the meeting on time. I'm Jo Boufford. I'm the Chair of the Public Health Committee. I'm happy to call the Public Health Committee meeting to order and to welcome members of the committee and council members as well as participants and observers. I want to go through the webcasting guidelines to remind everyone here that this meeting is subject to the Open Meetings Law is being broadcast over the internet. The webcasts are accessed at the Department of Health's website. The on-demand webcast will be available no later than seven days after this meeting, and stay on the site for thirty days at least, and then the copy will be retained in the department for four months. Ground rules to follow. There is synchronized captioning. It's important that people not talk over each other. The first time you speak, please state your name and whether you're a member of the council or DOH staff to assist the broadcasting company in recording the meeting. Also recall that the mics are hot mics, so please no side conversations during the meeting and or rustling of papers or other things that make it difficult to hear. And then for those in the audience, there is a form that you need to fill out registering your attendance that's required by the Joint Commission on Public Ethics. The form is posted on the Department of Health's website under Certificate of Need. There's an opportunity, I'm told. This is something new to me. As a reminder, there's a ninety-minute virtual training on health equity available to all members, and I encourage you to sign up if you have not already done so. The discussions and decisions of the PHHPC are obviously very important to all. New Yorkers and this sort of issue of health equity and addressing health disparities has been a theme of the prevention agenda since it started many, many years ago. We're suggesting that you take advantage of that, and Colleen can give you details if you need it in order to be able to be involved.

Dr. Boufford With that as preliminary comments, let me just review the agenda. I think Liza, you're with us instead of Cheryl. You're with us online. Liza will make the comments from Deputy Commissioner Donald. I just had a couple of preliminary comments after the welcome is that just to remind everyone as we begin today, the Public Health Committee is in fact the agent of the State Public Health and Health Planning Council for overseeing the sort of design as well as the implementation of the prevention agenda. What we are doing is from a regulatory point of view and statutory point of view exercising our responsibility here, and we take that responsibility very seriously. We have really asked to engage around this in sort of three, if you will areas. One being the prevention itself. It's sort of designing and implementation the second. Being the necessary interagency collaborations between the health department and other agencies to, if you will, leverage the domains of action that are imagined in the prevention agenda in these other areas over which other agencies really have primary authority and responsibility. Finally, collaborating with the Office of Primary Care and Health Systems Management on community benefit and advancing the exploration of that as a potential source of support and alignment with the prevention agenda. Similarly, I have not mentioned this in a while, but we also have agreement that we will need to probably refine the Certificate of Need language for acute care and other facilities to reflect a revision of the structure and organization of the prevention agenda going forward. This is an issue that's been raised before the council in the past. The other thing for the Public Health Committee is that we have each year picked

an issue that we want to work on. The issue this year is the public health workforce. We're delighted that Keshana Owens-Cody, and her team have been meeting with us frequently. They're going to give us some action opportunities. We've been looking for one where we can collaborate with the department in terms of advancing work on the public health workforce issues. The agenda today was really thanks to Mark and Liza. Covers each of these areas. I want to remind everybody, we're in sort of... We had mentioned this before, but we're inside of a data analysis period here where the joint plans for the local health departments and the hospitals, those that did them together were due the end of December and they're being analyzed. The hospitals were due at the end December. I think about 40% of the local health departments and hospital systems did submit a single plan. The local health departments were given an extension until July 1st. So, that data analysis is ongoing. I hope this meeting is going to push us to have more specific results by the time we meet again in December as a committee. We were going to hear sort of mid-course reports thing. What we wanted to do out of this meeting was to really engage all of you on the Public Health Committee and other members of council in your advice to what kind of data do you think would be useful in more final reports, what's missing from what you're hearing, what you want to be sure is included, et cetera. It's really seeking your guidance on what goes on the end of... Hopefully, the completion of these analytics by the time we get together again in December. We'll be hearing about regional meetings that have been going on around the state, as well as our first Ad Hoc meeting in the new cycle, which was held in September. Finally, we have Bella who will be talking to us about the progress on community benefit which was really led by or initiated in this cycle by language that the Legislature did put in the Governor's budget a couple years or so ago calling on the Commissioner to look at the language in the community benefit request and giving the Commissioner, if you will, permission to look at how that language might be modified. We'll hear from Bella about what the first steps are in that process and then what the plans are going forward. So, that's my sort of what I wanted to sort of set the, as I say, set the table for this meeting. We want to welcome Kathryn Haslanger, who is our new member of the Public Health Committee. Kathryn, you want to say a word or two? Maybe we could go around the table as well for your benefit.

Dr. Boufford You push the button, just push the button on the mic.

Ms. Haslanger Clearly, I have a lot to learn.

All (Laughing)

Ms. Haslanger I'm delighted to be here. This is a really exciting time to take on these issues. I was looking at the very ambitious plan this morning, early this morning and the dashboard. I see that we've set the bar really high and we have a lot of work still to do. I'm eager to be a part of it. Thank you.

Dr. Boufford Dr. Wilcox.

Dr. Wilcox Good morning. Welcome. Wendy Wilcox. I'm an OBGYN by training, Chief Women's Health Officer for New York City Health and Hospitals and a PHHPC member. Welcome.

Dr. Boufford Lindsay, Dr. Farrell.

Dr. Farrell Morning, Lindsay Farrell, CEO, Open Door Care Network.

Dr. Eisenstein Good morning. I'm Dr. Larry Eisenstein. I am the System Vice President of Community and Public Health for Catholic Health, all six hospitals on Long Island, and the former Commissioner of Health in Nassau County in New York, obviously.

Mr. Lawrence Good morning. Harvey Lawrence, former CEO of the BMS Family Health Center, now retired.

Ms. Soffel Denise Soffel, a long-time Medicaid consumer advocate here in New York State and long-term friend.

Mr. Waldenmaier Good morning, everyone. Mark. Waldenmaier, Director of the Office of Local Health Services. I would also like to introduce online, we have Dr. Elizabeth Whalen, who is our Executive Lead for the Prevention Agenda, as well as Mark Hennessy, who's our Director in the Office Health Care Systems Management and who just jumped on who's also from our team and has been a big part of the prevention agenda since the beginning, Dr. Zahra Alaali.

Ms. Elogoodin Good morning. Bella Elogoodin, Advocacy will be presenting a community benefit.

Mr. Lebwohl Good morning. Andrew Lebwohl, I am the Director of the Center for Long-Term Care Licensure Planning and Finance at the Department of Health.

Ms. Owens-Cody Good morning. My name is Keshana Owens-Cody. I'm the Division Director for Public Health Infrastructure at the Office of Public Health. Nice to meet you.

Ms. Norrell Hi. Erin Norrell, Associate Director, Division of Public Health Infrastructure and on the call, as well as Ashley Tate, who is our Program Manager for our new public health careers pathways program, which I'll talk a little bit about when it's my time.

Ms. Ngwashi Good morning. Marthe Ngwashi, an attorney at the Department of Health.

Ms. Leonard Good morning. Colleen Leonard, the Executive Secretary to the Public Health and Health Planning Council.

Mr. Stelluti Good morning. Michael Stelluti, Health Program Administrator, Department of Health.

Mr. Bintz Good morning Jacob Bintz, Program Aide, Department of Health.

Dr. Boufford Thank you.

Dr. Boufford Liza, it looks like you all are in your offices with a background rather than convened at all. I wonder if the members of the Public Health Committee and the council that are virtually with us might introduce themselves. I'm not quite sure how to do that most effectively in terms of their names. Maybe Colleen, you could call the name out. Oh, everybody else is a staff person or interested bystander as they say. Thank you for those of you that are here.

Dr. Boufford I wanted to mention that just a word of thanks in case we get too far ahead and forget to do it to Zahra Alaali for all of her work in analyzing the prevention agenda data. We're losing her to another activity within the department. I told her if she got bored

walking on a particular disease, she could always come back. We really appreciate it and look forward to your successors. Let me turn it over to you for opening remarks, and perhaps you can highlight those of colleagues from the department that could introduce themselves.

Dr. Whalen Good morning, everybody. Good morning, Dr. Boufford. As you mentioned at the beginning of your remarks, I'm here on behalf of Cheryl Donald, Deputy Commissioner for the Office of Public Health, and I am leading the prevention agenda for the state. I'm very glad to welcome our new member this morning, and today there'll be a lot of phenomenal information. I think we're at a really good, point poised really in the rollout of the 2025 to 2030 prevention agenda, and you'll be hearing a lot about this today. One of the things that I'd like to highlight, and I know Mark will probably be discussing is the regional meetings around the state which have just gotten such tremendous feedback and built a further momentum for the efforts of the prevention agenda. I think this is a great way for us to energize our partners at the local health department level, the hospital level, and the community-based organization level to really unite in the efforts around addressing the social determinants of health. This has been a big adjustment for us to utilize this format, but I think that we are finding out that it energizes people. There is a lot of creativity, a lot innovation, and a lot of discussion around how we can work together to improve quality of health and quality of life for residents across the state working together on this big agenda. I know you went over the agenda. We're going to be talking about workforce. We're going to talking about the regional meetings and what we're starting to hear back in terms of priorities from the plans that have been submitted. This will be kind of a teaser, and we will have more information on that at our next meeting. We're also going to be talking a lot about community benefit. I think the workforce priority of this group, there's going to a good robust discussion. There are a lot of things with workforce that I think this committee can speak about and hopefully make some recommendations on. One of the things that has been very important to me, and I will share with you those of you that don't know me. I was also formerly a local health department Commissioner at Albany County, but the role of public health nurses who are the cornerstone of really the shoe leather of public Health across the state. The inability for the local health departments to hire and maintain this workforce is a particular challenge, I think. Getting some feedback on that, discussing how we can work together on that I think is going to be an important use of our time. So, that's the only remarks I have for today. I also want to thank Zahra for her amazing work over the past few years in developing this agenda. We're very sorry to lose her on the prevention agenda team, but happily we are keeping her in the Office of Public Health. I look forward to continuing to work with her just under different program structure. Thank you so much for your work. That is all I have for today.

Dr. Boufford Let me ask Mark, because the community benefit area and Doug Fish has been so supportive of our including that in the conversation on the prevention agenda, Mark, perhaps you could introduce yourself to folks.

Mr. Hennessey Sure thing.

Mr. Hennessey My name is Mark Hennessey. I'm the Deputy Director of the Office of Primary Care and Health Systems Management here at the New York State Department of Health. Thanks for mentioning our Deputy Commissioner, Dr. Douglas Fish, who will be joining at some point soon. We just had a couple of things that we're working through, but we're very excited that we'll have the opportunity today. I know Bella is with you and we'll be talking about community benefit reporting, which is a really important new statutory provision that was put in place in which we've collected some information from hospitals

across the state. It's been a great opportunity to work with you all and look forward to continued work on that topic. We're very interested in what we'll hear from this group today and thanks so much for recognizing us as you're going through the opening process today.

Dr. Boufford Thanks very much for your support.

Dr. Boufford I'm over to the first item on the agenda, which is public health workforce and infrastructure. Keshana Owens-Cody and her team, you'll introduce your team and the floor is yours.

Ms. Owens-Cody Erin and I are going to...

Dr. Boufford Did you push the button?

Ms. Owens-Cody Oh, I thought it was pushed. I'm sorry.

Ms. Owens-Cody Erin and are going present on our updates as it relates to public health workforce and some recommendations and we're hoping to have a robust discussion with you all to move us forward. Thank you.

Ms. Knoerl Great. Thanks, Keshana.

Ms. Knoerl Before we kind of dive in, so I will say Dr. Boufford met with Keshana and I and tasked us to kind of say, hey, we've heard a lot about what you've been doing. What are some of the key issues and what are things that this group can kind of help tackle? As Keshana said, we're really looking forward to kind having a robust discussion with you. Before we jump into that, I did want to introduce it, so under our Division of Public Health Infrastructure, we just created a new program that we're calling Public Health Career Pathways Program. It's consisting of a few initiatives that we've been doing under the Public Health Infrastructure Grant and that we done looking at previously fellowships and kind of putting them together. I just wanted to do a high-level overview. This new program is consisting of several key initiatives; so, the Pathways to Public Health Internship Program, our academic engagement work. We have staff who are working, engaging with K through 12 programs, in addition to higher education. With the end of the New York State Public Health Corps Fellowship Program, we had established great relationships with the local health departments and community-based organizations. We've been trying to be strategic of like... How do we continue that work on, even if we don't have money? They've asked us about fellowships/internships. We have a new group of four staff who will be located across the state who are going to be working with local health departments on there... What we're calling pathways programs like internships, externships, apprenticeships and fellowships and kind of helping them figure out how they can kind of move forward on those initiatives as well, in addition to other opportunities like looking at existing state initiatives like the Empire State Service Corps and how can we integrate into that, working with Department of Labor and Department of Civil Service. Leading this new program is Ashley Tate, who is joining us virtually today. Ashley previously served as the Director of the New York State Public Health Corps Service Corps. She'll be responsible for overseeing and leading our program planning, design, implementation, and evaluation for these initiatives that I've mentioned. Overseeing all outreach and technical assistance to raise awareness about Public Health Pathways Programs, including key partners both internal and external. She's going to be facilitating strategic planning to address and advance the public health workforce programming at the state level. That means like pulling together those who's working on workforce, whether it be public health or

healthcare within the state and bringing everyone together we used to do that. I'm then also kind of... The Governor has a strategic blueprint on workforce and figuring out where there are areas that we can kind of interject public health in again to kind of leverage so we're not recreating the wheel. She'll be taking a look at that. I'd say one of the key things and she's on this call today is she will be working with this council to kind of on this workforce initiative, this special priority. Included in that is moving forward, presenting at these PHHPC meetings, providing updates on behalf of the department, briefing us back on what you all have to say on these initiatives, helping develop strategies to implement your recommendations, overseeing if there are any recommendations that the health department has to be involved with. I remember in previous meetings, you all spoke about developing a white paper, a maternal mortality. If we decide that's something we want to move forward with Ashley will kind of help with that initiative and whatever else we best see fit.

Ms. Knoerl Before I just jump into our report outs, I just wanted to give an opportunity to Ashley to introduce herself and if there's anything you would like to share.

Ms. Tate Thank you, Erin.

Ms. Tate Hi, everyone. As Erin mentioned, I'm Ashley Tate, the new program manager for the Public Health Career Pathways. I think you covered it, but I'm happy to be here and be working on this workforce initiative and to continue some of the work that was previously done underneath the New York State Public Health Core Fellowship Program.

Ms. Norrell Thanks, Ashley.

Ms. Knoerl We're going to dive into... We think are three key issues. I know there's a lot of different things with workforce, but the first one is kind of nursing, staffing shortages in local health departments, as Liza said. One of the reasons why we selected this is because it's got broad implications for the delivery of care of core public health services, especially in times of emergency, like right now when we think about the measles outbreak. We're in respiratory virus season. I mean, there's so many things that nurses are an important piece of the public health puzzle, and yet we kind of continue to see a decrease in the number of full-time employed nurses in local health departments. Looking at data from the New York State Association of County Health Officials, the number licensed practical or vocational nurses has been in flux when we look at the public health nurses or supervising public health nurse. Again, that number has consistently been declining. Vacancy rates is actually quite alarming when we at licensed practical or vocational nurses. You know, in 2022 it was at 29%. Then it decreased to 14%, but we're back up now in 2025 at 29% vacancies. When we're looking at public health nurses or supervising public health and nurses in 2022, it was a 20% vacancy rate in 2023, 29%. And then in 2024 and 2025, a 40% vacancies rate when we were looking at how many full-time equivalents are budgeted at the local health department but then compared to how many are filled. In 2025, the New York City Association of County Health officials said that's 695 full-time equivalents are unfilled in local health departments. That's the highest vacancy rate across all positions at a local health department. You know, talking with local health departments, especially with the licensed practical or vocational nursing title, several have told me that they've actually switched that title from having a licensed practical or vocation nurse to a different title because that was easier to fill, right? That they just weren't able to do that. Obviously for a public health nurse, you have to have that BSN degree. You have to do that so you can't just kind of switch out titles there. As we've discussed previously and many of you have brought up, one of the largest reasons for the

vacancy rates is salaries just are not competitive at the local level. We discussed this just a few weeks ago, Dr. Eisenstein. Brought this up to Liza and I at a NYSACHO, New York State Association County Health Officials meeting. You know, in Article 6, which is our entitlement program for local health departments with the state, you know, to help deliver core public health services, we currently reimburse salaries and are capping our fringe rate at 36%. Again, we're looking at innovative solutions on how to do that, but we think this committee might actually help move the needle on it a little bit more and think about strategies of how we work with counties to offer more competitive salaries. At that same meeting that I just mentioned, this question came up about public health nurses and what can the Commissioner of Health do to help local health departments out? He brought up something pretty interesting to us. It's not just a public health nurse shortage, there's an overall nursing shortage in New York State. There's just not enough nurses graduating from New York State nursing schools. Also, last Summer in 2025, the health department did a stakeholder summit on New York state's nursing workforce, and I have the final report, and I'll see if I can find an electronic version of it as well to share. There was some interesting findings there. One of them is that new graduates increasingly lack fundamental clinical skills due to pandemic-era stimulation training. That there are faculty and preceptor shortages, which represent a primary bottleneck in nursing workforce development as well. I do think we have to think about it from a broader perspective. We know that our Office of Healthcare Delivery has some money looking at workforce innovation trying to address nursing and we view our role is to try to be that voice for public health nurses overall. So, that's one of the key issues.

Ms. Knoerl I'm going turn it over to Keshana to talk a little bit kind of about Master of Public Health programs and academia at a larger scale.

Ms. Owens-Cody Thanks, Erin.

Ms. Owens-Cody One of the things that we wanted to also bring up is challenges or things that were learning as we've rolled out the fellowship program, but then also the Public Health Infrastructure Grant. We've done a lot of work in terms of engaging colleges and universities, as well as K through 12. Many of our teams are going into elementary, middle schools, high schools, and participating in some of the supplemental education, educating students on public health, public health careers doing different experiments just so that they can get that hands-on opportunities in the classrooms, going to a variety of career fairs, educating students on careers in local and state government public health, but recognizing sustainability of all of that work post a lot of the different federal awards that we've received. Oftentimes, we've talked about the COVID cliff as it relates to some of our services and programs that have gone out, but I want to kind of emphasize how that also impacted Pathways into public health. There are a variety of federal... Sorry, I think we lost audio.

Ms. Owens-Cody Can you hear me now?

Ms. Owens-Cody Can you hear me now?

Dr. Whalen Yes, I can. Thank you so much. Sorry for the interruption.

Ms. Owens-Cody No, no problem. We want to make sure you guys can hear us.

Ms. Owens-Cody One of the things that we've recognized with the COVID cliff as it relates to Pathways programs is whether we've lost or we have reduced funding in a lot of

different areas. One example is looking at some of the epidemiologist programs that we had in terms of those graduates who are coming out of school, being able to be placed in a variety of different settings within state government. Some of the funding has been reduced there. We lost our New York State Public Health Fellowship Program, because it was on a federal award that was related to cover as well. And just thinking about the Public Health Infrastructure Grant, many of us know that that is also supposed to sunset in November of 2027. We're entering year five in a couple of weeks. We've built the infrastructure, I would say around Pathways. One of the things that we're noticing is that in order for us to sustain it may not be able to come from the from the federal level, but there's a lot of opportunity we feel to align with some of the initiatives that are coming out of the state. Erin did mention the Empire State Service Corps. We kind of stumbled upon that. We happened to find out about... Is everyone familiar? I can give a brief overview. The Empire State Service Corps for those that don't know. Is a fellowship or internship program, it looks like, that SUNY has created for all of their SUNY graduates. SUNY Graduates have an offer, or not SUNY, sorry, not graduate students. They have an opportunity to get some hands-on learning and provide service to the state. We just happened to be looking at some of the categories or where students could be placed. One of them was like food insecurity, mental health counseling, and we saw climate change. Because one of our academic liaisons is always out trying to understand what our students are looking for in terms of jobs, what their interests are. We said, wait. Climate change. We know we have some host sites. We can look at local government and local health departments. We can at our state government. We reached out to Empire State Service Corps and said, hey, we're public health and did some education around that. I feel like this group can help us with what other areas we could be aligned. Could we be pushing public health as a focus? Another things that we've thought about is State Ed, as it relates to making sure like public health is a program or a course that's offered to some of our high school graduates, maybe even getting into our middle school and elementary settings. We do know from a vocational standpoint, we have engaged with a couple of the schools that have public health as a vocation opportunity for students. So, that's one area. We've had discussions in the past about public health, graduate studies, the finances around it, and the landscape that's changing there too. Maybe partnering with HESC to see if there's any of the scholarships or funding opportunities that they're giving out, how can we kind of insert public health in those spaces too. Kind of looking at this group to help us with a lot of alignment with other state agency work that's happening. Because sometimes that's kind of a blind spot to us as we're. We're pushing the work forward. Another thing that I will, before we open it up for discussion is one of the things that we're talking about, I would say amongst all jurisdictions as it relates to the Public Health Infrastructure Grant is we recognize... You know, we're leveraging a lot of data that helps us to understand like who is coming into public health, who works in public health. What we've learned even in the fellowship program is that about half of our workforce that's coming in doesn't have a public health degree, doesn't have a public background. One of the things that we've been really good at is making sure that we’re getting some of the investments that we're getting, we're working and collaborating with different colleges and universities to offer that foundational public health, like almost like an intro to public health for our workforce, but why stop there? Is there an opportunity for us to also push into our undergraduate institutions and see if Intro to Public Health could also be offered in those settings? Many of us probably took Intro to Sociology, Intro to Psychology, like those are required courses. Could Intro to Public Health be something that's also offered? I say that in two ways. One, it's also just educating broadly what public health is to every discipline, but then also it gives that opportunity for us to raise awareness of public health careers as well. I'll pause there because I would imagine off of just some of the things that we've said that there might questions or thoughts on how you can all help us with this too.

Dr. Boufford Great. Thank you very much.

Dr. Boufford I'm going to open it to colleagues.

Dr. Boufford Dr. Eisenstein has his hand up first.

Dr. Eisenstein Hi. Larry Eisenstein, committee member and council member. Thank you for the presentation. We've discussed this before. I feel very strongly that this is solvable. I think it's easily solvable if we can just get the buy-in. We've... For years and years and year, as long as my twenty plus year public health career has been going on, we've been talking about the shortage of public health nurses. As a doctor, I will tell you, nurse is the single most important job there is on the planet. I don't only say that because my wife's a nurse and it makes her happy, but it's financial. It's not rocket science. I've said this to you guys before. You've heard it from me. So, rather than keep saying at the health department, the starting salary was half what the hospitals were paying. You can't compete. It's always going to be a shortage. The answer, the solution, rather than me just whining is legislation, which one day is going happen because I'm going to keep pushing for it is to legislate the starting salaries for public health nurses. We know the average starting salary at our hospitals on Long Island or in New York City or in whatever region is X amount. By law, public health departments have to pay their nurses 80% or 90% of whatever the starting average salary is. Your shortage of nurses is systemic. It's beyond public health. It's financial, number one. The only people willing to be nurses in public health are A, there for another benefit like health benefits or whatever for their family, or B, just the hours, or C, it's the mission and they can financially do that. Very few people financially are in the position, especially with school loans, to be able to do that, so to me, you can call it the Larry Eisenstein Law one day because this is going to happen. It's not only nurses. Nurses is what you highlighted. Engineers. We want clean water. How much do we hear about clean water? Clean water happens in New York because there are public health engineers. What happens is they come to health departments at a school, have to do their few years. It's kind of like residency training to get certified. After that, go to the big engineering firms for three or four times the salary. There are shortages in engineers. How about your commissioners? The commissioners of health in the counties and directors. I'm sure Dr. Whalen isn't going to argue this point with me. She and I were both commissioners of health at the same time. Our salaries were half the average doctor's salary. Why would the top people want to come to a health department for half? I'm at a point in my career with kids in college that I couldn't go back to being a commissioner of health no matter how much you all begged me to do it, right? That doesn't really happen, but I can dream. But the point is, why would the people in any of these fields work for half the money in public health? A few will because of the mission, a few will because of circumstances, but the shortages are not coincidental and I keep preaching it. And to me, all we need is to legislate the starting salaries for public health nurses at public health departments, and overnight your shortage would be gone. Because then people would be fighting to get governmental 9:00am to 5:00pm public health jobs rather than working overnight shifts in hospitals. I now work for a hospital system and I'm saying this. I've been preaching this. As far as well the county budgets, and Nassau County Department of Health, I think had six nurses when I was there. It's a county budget of multiple billions of dollars. You're talking tiny, small amounts of money. Nobody in the union is going to object to higher starting salaries. To me... It's a win/win/win for everybody. Most important, it's a win for the health of the community and that's what we're here to do. Second quick thing. We talk a lot about the COVID cliff. That's obviously real. This is a problem that predated that. I had nursing shortages long before COVID. I think

COVID is real. We have to talk about it. This isn't new. I think that we sometimes like to point that COVID is the reason for our problems. This is a simple economics problem. I have no training in economics, but I understand supply and demand. Lastly, you talked about the value of an MPH. I have an MPH, I preach MPH. I've taught MPH and MHA students for many years at Hofstra and Stony Brook. I've done lectures everywhere and have counseled numerous students. A lot of them would come to me with the question... I want to get a master's degree, should I get an MPH or an MHA or an MBA? I used to believe that there was value in all of those for everybody, some people better geared for an MBA, some better geared towards an MPH. Now, I've been at a health department and in a hospital system and on this council and seen... It's getting harder and harder for me to justify advising people to get an MPH. I teach MPH students is my life's work. But the reality is... The landing spots, I could tell you, at a hospital that MBA is way more valuable if you're coming in as an unknown entity than an MPH is. There's very few people like me who understand the training and the value of the MPH. Perhaps we need to revisit from a higher level and an academic level... Where are people landing? If the MPH jobs pay so much less coming out, because they do. If you have an MHA or an MBA you can go be an executive not only in healthcare, but in any area. If you have an MPH, you're hoping to get a governmental job at one of our great agencies. Again, love the state and the county health departments. It's my life's work. Practically when kids can't afford the rent, they can't afford to stay here in New York because you're graduating and now you're getting a master's degree and you're paying $1,000 of credit or $1,500 of credit. How are you going to pay rent on Long Island or New York City if your first job is $35,000, $40,000, $45,000? Those are literally some of the starting salaries for MPH students. Again, it's simple economics. Until we legislate growing the salaries in public health, we could keep having this discussion. I've been hearing it literally for twenty years, and it simply comes down to, we need to pay our public health professionals what they're worth. It's a societal thing. My recommendation to this group and to the state health department and to state health commissioners, let's find advocates who can legislate this and get it done instantly. Your shortages may not disappear totally, but they will level the playing field and at least give the health department a chance. That's my view. Sorry, I went off.

Dr. Boufford I think you've well covered the financial angle of this, which is really important. It's really fundamental.

Dr. Boufford Other comments?

Dr. Boufford Yes, Lindsay.

Dr. Farrell Lindsay Farrell. There's a severe shortage of primary care clinicians. In federally qualified health centers, we've had to be incredibly innovative in the way we organize our workforce. We're currently relying on nurse practitioners and physicians' assistants. There's also a terrible shortage of psychiatrists. We are using licensed clinical social workers and have had to develop sort of new models of care. I think it's kind of well understood why primary care is just not exactly as attractive as urology, dermatology, radiology, and all those other ology specialties. There's a structural thing that we are all up against, and certainly public health is up against. I have an MBA, by the way. I worked in public health, and so I figured I didn't need to go to school in public health. What I needed to understand is finance. All the power is certainly on the insurance side. If you land in an insurance company, you can do extremely well. My recommendation is to really sort of thinking a little bit more innovatively about the workforce, moving beyond the medical model. Health and wellness is such an incredibly hot area. Our healthcare system needs to get away from a sick care system and toward a well-care system. Public health is

absolutely the place to do that. In New York State, you have to take a health class, I think to graduate. I think that's a requirement. There are opportunities to sell public health and health and wellness at the high school level, which then could direct students along the pathway as they enter undergraduate and graduate programs. I do think thinking outside the box is really. I know when I wear my managed care hat, we are extremely frustrated about primary care, and I run a primary care system, because primary care is like four walls, and the primary care system is not moving as quickly as consumers are. You would like to have your aura ring, and you can order your own lab tests. Why would you sit in a waiting room waiting for a clinician who might not necessarily appreciate the time constraints that you're under. There's a lot of sort of thinking out there in the world of technology and innovation about how we might organize things differently. I think that there's plenty of resources out there to sort of tap into from innovation and then utilizing technology in health departments. I think probably the last place where technology is widely utilized. Again, partnering with companies to be able to expand the capacity of the workforce I think is very important.

Dr. Boufford A really important point. I want to be sure that we understand that we're having the conversation we're having is how we can help with them to raise these issues. My lifetime in primary care are certainly the issues I think we're forming the health care system in the way it's financed in New York State is certainly an opportunity to address a number of these issues. I want to kind of just keep us on that conversation, because we're not telling them to do stuff. We're trying to figure out what we can do together as a council. It's a really important set of issues, Lindsay, that you raised.

Ms. Haslanger Thank you.

Ms. Haslanger I was a little concerned about touching the third rail in my first meeting, but Lindsay kind of opened it up.

All (Laughing)

Welcome Dr. Boufford.

Ms. Haslanger I feel like I've been in this conversation in the home care and community nursing setting. One of the really important things that you said in your framing is that we are dealing with an overall nursing shortage. It raises the question of... Is everybody operating at the top of their license? Can we look at the whole delivery question in a different way? There are certainly areas where we could try to find champions and advocate. There are areas where models have been developed so that we can build evidence and take the case farther. New York has not been in a leadership role. We need to reassert our leadership role in this area. That's certainly something that we could do that would help solve this problem. I mean, sort of that just like an arms race, right? You throw a little bit more money at the public health nurses. Home care wants to throw us more money at the home care nurses. Nursing homes are struggling. I mean, it's an arms raise. We really have to, I think... Think more yes. Money is important. There's a lot of social workers that are doing public oriented social work jobs, making half of what they could make if they were working for a managed care company. There is that kind of salary disparity more broadly. I don't know if we're going be able to just rewrite all those rules but rethinking what the roles are and looking for some different ways of building skills and building career pathways. I think we could be really important and could help with our equity agenda at the same time, important.

Dr. Wilcox Thank you.

Dr. Wilcox To piggyback on all of the really appropriate and important comments that we just heard. I do think we have to think about how we keep our workforce in the state, especially those who have trained here, and then may try to leave for other states that are perhaps more affordable. I do you think there's a huge opportunity in scholarship slash, workforce promise or receiving a more economical way to go to school and then having an obligation to stay and work in New York State for a certain amount of time. It's not a new idea but certainly tied to the shortages that we now see, a few of those well-placed scholarships in our SUNY system could really serve us well. Also to put a plug in for psychiatric nurse practitioners. We've mentioned all different types of nursing but knowing that we have a shortage of psychiatrists and mental health providers, I think certainly getting people to operate at the top of their license would make a lot of sense. Thanks. Oh, oh, wait, one more thing. I'm sorry. Also, dual degree programs. It wouldn't actually be a novel idea. You know, you get your BSN and public health degree maybe in a little bit more time, six months to a year, and again tying it to scholarship and workforce obligation could really work well. Thanks.

Dr. Soffel Denise Soffel, a committee member and council member. This is not a fully thought through thought, but I thought I would throw it out there anyway. I'm thinking about community health workers and the energy and the investment in CHWs that we've seen over the last number of years and wondering whether there's a way to create career paths for CHW's into the public health workforce arena, or the other way around. I'm not exactly sure how it works, but it seems to me we've seen enormous enthusiasm around developing the role of CHWs, and that should be at least some way to think about how to build similar momentum and enthusiasm for the public health workforce.

Dr. Whalen Dr. Soffel, you have with you a subject matter expert on that in Keshana Owens-Cody, who teaches community health workers.

Ms. Knoerl I will just put a plug in because Ashley's team worked really hard on this. You all received an electronic copy. You have a hard copy at your table. This is on the New York State Public Health Corps Fellowship Program. On Page 13, they talk about how theoretically a fellowship could work to bring in community health workers, public health nurses, different like pathway programs as well of people fresh out of school as well. I do know there is under the Medicaid waiver as well, the CPT, which stands for career pathways.

Ms. Knoerl That is one of like nurses and community health workers are eligible where they're getting their schooling paid and then they have to give a commitment back. For a while we thought local health departments were not eligible and then we learned a few weeks ago they are. We're going to be further looking into that, but I think you're right on point of like can we think about this innovatively as well and then just sometimes though some of these programs that require money, so then figuring out how do we get someone to invest in us to kind of do these innovative ones? No, I think everyone's on point. We've both been taking diligent notes as well.

Dr. Boufford Any other comments from council?

Dr. Boufford I wanted to first welcome Dr. Fish and thank you for your support around the community benefit work, and then I saw Cheryl Donald there for a few minutes, but she

may have had to go to something else, so we wanted to welcome them to the discussion. I want to try to connect some dots.

Dr. Farrell Yeah, you mentioned psychiatric nurse practitioners. Again, because we're so siloed in New York and because the mental health system is completely separate from the medical system. Again, when you're on the front lines, like when you are in a primary care practice, you have lots of people showing up on the medical side that have mental health issues and vice versa. The systems don't speak to one another. That creates some of the burden on folks working in primary care, because it's so difficult to navigate between the two systems. We actually created a position, which is like a community health worker, that can kind of do some of that navigation. I just encourage you to kind of think beyond New York State Department of Health and think, you know, similarly OASAS, right? It would be so wonderful if these systems could work together more effectively, because indeed, these are the public health crises of our time. We're very fragmented. We don't have good ways of serving the people that we take care of and the communities to whom we are responsible.

Dr. Boufford Yeah, maybe I can use that as a takeoff for a few comments. One of them I think that's really important that you've just highlighted is part of the prevention agenda that is built around interagency collaboration. We do have an opportunity, I think, with OASAS and OMH and the Office of Disabilities has been actively involved as sort of core partners in the prevention agenda, many other agencies have been involved, Ag and Markets, Department of State, Education recently. I want to come back to that. I think that this framing of the conversation with other agencies to find out what they are doing. I'm sure they're being asked the same questions. It's really important for us to think together with them in this workforce issue. One of the opportunities we might have relating to ways in which this committee has been helpful in the past is really putting together some panels and some sessions to bring people in from these other agencies and talk about this dilemma that is in the public health space... How are they addressing it? How are they dealing with some of these issues? I think we want to think about that issue. I want to be really, opportunity, let's say that. I want to talk about the sort of the budget issues. I raised this with the Commissioner the last time the council met. There was a very significant add-on to the personal healthcare delivery system workforce. I think it was a year ago last Spring and then tens of millions. Doug probably knows how much money this was. I'm not sure. Tens of millions of dollars because of the advocacy, certainly, for the shortage needs that we're facing in the clinical system. I think we have pretty much, you have described to us the significant sort of shortages, vacancies in the public health sector. I take Dr. Eisenstein's point about competitive salaries. In addition, most of the money that was funding your public health fellowship and some of your others was federal money passed through and is gone. I think one of the questions really before the department as we move into budget planning season is... How could there be an estimate of some funding support at least to replace the public health fellows to deal with some of the sort of marginal areas, some of issues you've talked about as a sort of public health workforce budget going into the legislature? I just want to put that out there because I think it's an important question to ask, and I think this committee will keep asking it going forward, and all you can get is a no. If you don't ask nobody can give you an answer. Part of the exercise would be framing what amount of funding would make a difference. Obviously, in the personal health care space, it's tens of millions of dollars. It probably is not that in the public health space. It might be a manageable number, even if it were restoring federal infrastructure. Support is a first step towards a broader investment. The other thing I wanted to mention, which again relates to the structure set up around the prevention agenda is our first speaker in the Ad Hoc committee meeting in September were two very high-level people from the

Department of Education who are interagency engaged with the Ad Hoc committee. One is the gentleman I found out having chatted with him on the side who is responsible for scope of practice decisions in the State Education Department. Similarly, we had a member of the Board of Regents who was at the meeting. They both presented their activities. They shared with us, and Mark distributed it later, their sort of internal health-related strategy, which we just learned about in their presentation, which deals with what is the well-equipped high school graduate supposed to look like in the state of New York, and that document we distributed to everyone. The issue is really in taking advantage of the agencies that are committed to the prevention agenda, again, around a discussion of how some of the issues you're talking about with no resources might be integrated into curricula or into activities statewide. They were very open to that conversation. I mean, they're dealing with fresh fruits and vegetables and exercise and a lot of other issues, but also the issues of how you build into these curricula where you're trying to get entry points some of the broader sort of health education agendas that we might have. Again, taking advantage of that inter-agency connection which has been established as part of the prevention agenda is the conversation I think to have regardless of funding or not because these folks are, they have money, they're thinking about curricula, they're thinking about emotional intelligence curricula. There are a lot of standard things in these other sectors that we don't know about. I think that's part of what the interagency conversations are about. So, OMH, OASAS, we talked about for one set of things. Similarly, the Department of Education for this other conversation. I think it would be really also helpful for us to hear from the colleagues in the health care delivery side of things that are dealing with workforce. It was one other that I was part of a number of years ago on the sort of health sector workforce in New York which looked at the clinical as well as the public health. We haven't done that in a long time. I think it would be really interesting to hear from them what the issues they are facing, how that funding was used that was made available before. Was it one off? Has it been picked up by the hospitals? Just to understand the mechanics of how that worked in the budget. We could talk about this going forward. I'm just trying to steer us towards the kind of conversations that we can have as the Public Health Committee on behalf of the Public Health Council to begin to tackle these issues that you've raised, all of which are really, really important and really, difficult ones. I know the New York City Health Commissioner has made funding of community health workers under Medicaid his number one priority. That's all he's talking about in New York City. Not all he is talking about. He has three others, but that's a major one. I think we've talked for a long time, a lot of community healthcare workers, the group for many years comes out of more of a clinical orientation. If you're doing home visits, why not look at the home environment if there's guidance there as part of your training? Why not at some of the environmental risks in these communities? There's no reason why. I like that idea of the pathway for them into public health as well. I also wanted to mention one of the other, the two other presentations we had, one was from the Department of State on economic development, which is one of our domains and then we didn't have a formal presentation from the Department of Transportation, but we had senior people there who were talking about the sort of issues of local zoning issues around setting up bike lanes and more much more activity green space blue space in terms of urban planning and cities. All were interested in those conversations. I teach in a School of Public Health at NYU. There was an article about two years ago called Public Health 3.0, which is basically saying that the next generation of public health people are custodians of the community's health, and their job is to talk to other sectors who have, in the aggregate... Probably much more influence on producing health and preventing premature death than the health care delivery system. That has been known for many, many years, and the evidence base is pretty strong. I think it's an opportunity for us to kind of connect the public health workforce shortages with some of the other elements and resources that are available through the prevention

agenda structure. We want to really look at that. I'm glad you mentioned the public health fellowship report. I was going to ask about that.

Dr. Boufford Dr. Whalen, you wanted to speak as well. Please, please, please, please go ahead. I wasn't looking up. I was looking down and aside.

Dr. Whalen No, and I don't know if, for somehow I can't figure out how to raise my hand. I apologize for that. I think that this is a group that could probably talk about workforce for every minute that we have time together and then some if we were here for, because there are societal larger pictures of this. I want to rein something back in. Community health workers, first of all, I agree 100% they're an essential workforce. A lot of local health departments, and when I was at Albany County Health Department, we've been employing community health workers since the 70's, and they go out and they address the social determinants of health before we called them social determinates of health. They look at where people are living. They look how the struggles that they have to get food on the table, feed their families, and address how they get medication, et cetera. Great workforce needs to be buoyed. Needs to have pathways for people who are community health workers to continue to advance through the field. I want to focus on the nursing piece and I'll tell you why. Public health nurses are a very specialized workforce. What do they do? Well, they provide immunizations and things that the local health departments do, but in maternal child health programs, which is a core public health program, they go out to homes with high-risk pregnancies, and they weigh babies in the home, and they talk to the pediatricians and they create plans. They work on local health departments that have, for example, Healthy Neighborhood programs with asthma. They are asthma nurses and then can go out and create with the pediatrician an asthma action plan for a child who lives in a high needs neighborhood that has lost loads of days of school because of asthma. This is a really specialized workforce. Another thing I want to say about it, the nurses and public health nurses at the state were advocated for and got a raise. Physicians at the state were advocated for. Bureaucratic challenges that unless the nurses are advocated for as the nurses being advocated for, they will not get necessarily raises because Article 6, which was discussed is money that the state gives to the locals to support their public health programming. There is a base grant that is given to every county dependent on their population and other things. There is reimbursement, 36 cents on the dollar. The base grant was raised probably four years ago, Larry, I don't know, which was the first time it had been raised for ages. I, at the local health department level, said, great, I can get the nurses raises. This money did not go to that because, as you point out, there are other people and other programs and other services. Within the context of local government, this often goes into the county coffers in general and does not support public health nursing. Thank you, Sarah, it was 2019. Oh my gosh. I'm dating myself four years ago. Well, maybe seven years ago is more like it. I just think that there is merit for us advocating for this particular workforce. I agree. We're looking at people operating at the highest level of their scope. We have health departments that are now having problems hiring commissioners for the same reason. Again, for local health departments that are commissioner counties that are headed by you have to have an MD and an MPH, so you're pretty specific in your skillset and then there are director commissioners. There are public health nurses and then there are people that are helping public health nurses. I do just speak from experience and think that this is a great workforce to advocate for in particular.

Dr. Boufford I think that's a really important point. Again, we could bring in sort of nursing leadership from the state to really talk about this or from the healthcare delivery side as well. The other thing I think is we do have a representative from the New York State

Association of County Executives on the Ad Hoc committee and who attended the meetings. I think these are the kind of things, these connections that we can make outside of the Department of Health. We've got to do that. I think all of this conversation is an exhibit. Obviously, we can have leadership internally and do what we can, but in terms of some of the leverage that exists in the other departments and other agencies becomes really important. I'm not saying they're going to give us the money, but I'm just saying it's linked to what Liza's talking about relative to an awareness and a conversation. I think our colleague, a member of the council, who's also just become President, I think of NYSACHO, Dr. Watkins, Kevin Watkins. Has just become President of NYSACHO, and he was very articulate in his last conversations as being a very core partner with his County Exec as part of, you know, sort of the special challenges in rural parts of the state

Dr. Wilcox May I ask a question?

Dr. Boufford Yes, Dr. Wilcox.

Dr. Wilcox Is there any way to earmark the money that comes from the state specifically for the nurses or is that not possible?

Dr. Whalen So, that's a good question. Sarah, I see you're on this meeting Sarah Ravenhall, who heads NYSACHO and maybe a little bit more of a with the ways that this can be done. I think there must be.

Ms. Ravenhall Hi, everyone. There's absolutely a way. It would require a statutory change and some more specification in budget language. We could certainly put some kind of parameters. We could look to put some parameters into place that allow for the payment of salaries up to X, Y, Z under Article 6. So, depending on the availability of funding to do such a thing, I think there is a way. Again, that would require the Governor and legislature to be involved.

Dr. Wilcox Thank you.

Dr. Boufford Part of what we want to do is make these opportunities visible so they can be potentially considered and carried forward to the appropriate decision makers as they say.

Mr. Lawrence Harvey Lawrence, member.

Dr. Boufford We've got about five more minutes on this topic. Otherwise, we're going to because I have one more question to ask you guys before you go and then we have to move on.

Mr. Lawrence I thank you for the presentation and for the discussion. I think I've learned a lot about the public health nursing. The question though and gets back to MPH programs and MBA programs is always whether it is cost-benefit or cost-effective. The question is whether you have done that analysis and it's come have developed a presentation that outlines the overall public benefit and the cost associated or the savings associated with the benefits of public health nurses in the health system.

Dr. Boufford I don't want to go off too much on that. I think the part of what we're talking about at a higher level is return on investment for prevention and for the various members

of the workforce who really engage, whether it's conditions in communities or in the clinical space, I think is really important.

Dr. Boufford Dr. Wilcox, one last statement.

Mr. Lawrence No, I understand the bigger picture in terms of benefits, but also I think if you're going through the budgetary process, there seems to be a presumption that people know, and that may not be the case.

Dr. Boufford No, absolutely important point. The return-on-investment argument you always have to have available for dealing with political leadership.

Dr. Wilcox From someone who has one of each, and I went back ten years later after getting my MPH to get my MBA, the MPH was partially paid for because the boss who I was working for at the time when I posed this to him was willing to pay for the Mph and not the MBA. Ten years later I said, I don't want people to question what my MPH is in, because there's a million different things you can specialize in. I went ahead and paid for my own MBA. I'm just saying if we're the people who are trying to direct the workforce and getting more of the workforce we need, then there's certainly a way to direct the money so that we get the end result that we need in the workforce.

Dr. Boufford Last comment, Ms. Farrell.

Dr. Farrell Yeah, I just feel compelled to note that there are times when federally qualified health centers are actually competing with health departments. I'm sorry that Patsy isn't here. And so, for example, the health department does immunizations. We do immunizations. Children are covered through Child Health Plus. Yes, it's all well and good to have a clinic every now and then where there's a public health nurse. I'm open six days, sometimes seven days a week from 8:00am in the morning until 8:00pm at night. It's much easier to get your vaccine in a federally qualified health center than it is in a public health clinic that's only open Tuesday afternoon and Thursday afternoon. The competition for these critical members of the care team really shouldn't be. So, that's why I'm a little reluctant to say, oh, put an earmark in for nursing salaries when we are so desperate to hire nurses and yet we have a more innovative model. Federally qualified health centers don't yet have legislation that allow us to have medical assistance giving vaccines, for example. You know, this is a multi-tiered problem, but we would never want to be in competition when there are duplicative resources in the locale.

Dr. Boufford I think maybe ten or fifteen years ago, there was a movement to try to move so-called clinical services out of public health departments into community health services centers, hospitals, and others. It seems like we've reversed around. Part of the reason, obviously, is Medicaid reimbursement for those services. So, that had been a big national debate about the role of public healthcare going forward.

Dr. Farrell The nurses would roll in and set up. I'm like what? Do people only get TB on Tuesdays and Thursdays? People are exposed to TB all the time.

Dr. Boufford We need to explore where that direction has gone. Mr. Lawrence is going to kill me if I don't let him have one more word here.

Mr. Lawrence I want to thank Lindsay for that point because it drives home the point that I'm making about being able to do that sort of global cost benefit because it allows you to

look at what others may be doing more efficiently and also look at where public health nurses should be focusing on and the value added that they bring to the healthcare delivery system.

Dr. Boufford Thanks very much.

Dr. Boufford One question I wanted to ask you all. We had talked about an option, which I didn't hear you mention it, maybe that you're still in a thinking phase, but about trying to develop a statewide organization of deans and directors of schools of public health like there are for medical schools and nursing schools and dental schools. We made a sort of a board of effort to try that a few years ago. We didn't work out. Obviously, this was pre-COVID. It's a challenge. A lot of the issues you're raising, being in a school of public health are really issues that are on the front burner for deans and directors of public health. A lot the graduates in public health for some of the reasons we've talked about for the last hour or so...are not really looking at health departments. Many of them have career paths into pharmaceutical companies, into the transportation departments, into the housing departments. I think part of it is creative. Lindsay was mentioning, or everybody was sort of... Let's think outside the box. I wanted to know if you had discussed that any further. Again, that would be something I think that we could... By bringing folks together in a sort of public space maybe at least put out the challenge to deans and directors of public health to talk among themselves and see if they, because I think it's an advocacy voice that's missing in the education space, much of which you've talked about.

Ms. Knoerl I can speak a little bit to that. Liza, feel free to jump in as well. So, I had a conversation with Dr. Erin Bell from SUNY Albany College for Integrated Health Sciences. So, UAlbany has a relationship with the State Health Department. We're an academic health department. The Office of Public Health has been working with Dr. Bell. Laura Trollio let me know that. Dr. Bell was going to convene all the deans of the schools of public health. I said, oh, well, she's going to do that... Can I talk to her? Because I know it's been raised here. I did meet with Dr. Bell. She is convening those deans, I think like maybe quarterly, or at least like a few times a year. She's very interested to come and learning more about PHHPC and to be part of the conversation as well. She mentioned to me too, and I spoke with Keshana about this yesterday, like public health is no longer like designated for certain loan to be able to take out a loan federally on that, it was kind of taken off the list. There are a lot of concerns that she has. I sent her some information about PHHPC, but she said, yeah, she would kind of convene with this group and bring members alongside if there's interest.

Dr. Boufford, I think to get the maximum amount of advocacy, we want to be sure to bring in deans and directors of schools of accredited programs, as well as the deans. I just want to mention Professor Kyriacou from Hofstra hosted the meeting Monday that Larry and I attended on the Nassau-Nassau and Suffolk County regional meeting and was very articulate and extremely interested. I mentioned in passing that this had been discussed. She might be a really great downstate partner for Dr. Bell. Maybe we could bring both of them in again, but she was very keen to get involved.

Ms. Knoerl I think for the most part she mentioned that she's meeting with SUNY deans. Again, if there are ones outside of that...

Dr. Boufford There are many and I and I think we've got to really get the broader. There's seven Schools of Public Health in the New York City area and one of them is SUNY. The rest of them are not. One is CUNY, one is SUNY and then the rest of them are...

Ms. Knoerl It's on my to do list to loop her in with you, Dr. Boufford, to figure out again, what's the role of PHHPC and how can we work with the deans as well?

Dr. Boufford Okay, great. Thank you very much.

Dr. Whalen Yeah, just a very one last very last comment about FQHCs and their importance in working with the local health departments. Again, not speaking in my current role, speaking in my past role. There was never any competition. This was a workforce that we worked with very closely on very many initiatives. I still get texts from the CEO of the Federally Qualified Health Center in Albany. Because we had such a good partnership. It developed into a friendship. The local health departments, vaccination, clinical services, buy in. I understand that. These are people that go into homes, that go into homes of high risk. People in underserved communities. It is a real skill that we're losing. So, just wanted to say that I never felt that there was any kind of competition. It was always a complementary relationship.

Dr. Boufford Thanks.

Dr. Boufford I'm going to move on, because we have two other major presentations and people queued up to play their role. Obviously, this is an area of a lot of interest, enthusiasm, and a lot great ideas. Maybe we can try to sort of summarize potential next steps and then think about how we might probably, at this point in the new year, since we have one meeting coming up in December, we really need to hear sort of the results of some of the analysis that has been going on in the last year or so to really plan a set of sessions that could really bring these issues out, bring them to the fore, do some... That always requires pre-work, so we have time to do that. Thank you very much. You have our engagement with you, obviously, from what you've heard.

Dr. Boufford No, it's at the end. At the end, please. We want to get through the whole agenda that anybody can have there, they can choose on the menu of things we've talked about that they want to discuss.

Dr. Boufford Let me turn it over now to Mark and just let me remind everyone we're sort of in the midst of analytic process. Mark is going to give us some sort of high notes on some of the activities that have happened since our last meeting but also sort of where we are in the analytic process and what we might expect in December.

Dr. Boufford Mark, over to you.

Mr. Waldenmaier Thank you.

Mr. Waldenmaier I'm actually going to, since we already talked about it a little bit, have the NYSACHO team and Grace Dawson, who's the project lead first talk about the regional summits that Larry and Dr. Boufford had been able to attend earlier this week, because you do also have, that was sent to you and have a hard copy of one of the first outputs of that project, which was the needs assessment that was done across the state and is informing those summit. I'll yield the time first to Grace to start us off on that topic.

Ms. Dawson Thank you so much, Mark.

Ms. Dawson I'm going to start by sharing my screen. We have a presentation today to go through some of those preliminary needs assessment results and as Mark said, give a little bit of an overview of how the regional summits have been doing. Thank you everyone for the opportunity to present today. As Mark said, my name is Grace Dawson. I'm a Senior Program Manager for the New York State Association of County Health Officials, or NYSACHO. NYSACHO is the membership association for New York's local health departments supporting local public health efforts through programming, technical assistance, and statewide advocacy. Today, as I said, we are here to provide an overview of the Prevention Agenda Health Equity Award to the committee. This project, a partnership between NYSACHO and the New York State Department of Health, under their Office of Local Health Services and Division of Public Health Infrastructure is aimed at supporting local efforts to implement the prevention agenda priorities in communities across the state. This project runs through November 2026. It includes a needs assessment of prevention agenda stakeholders, five regional stakeholder meetings to bring together local health departments, hospitals, and their CBL partners, and a final report on project activities, findings, and recommendations. You will hear more about the needs assessment findings shortly from one of NYSACHO's subject matter experts, Sue Ellen Wagner, but first a brief snapshot of how the regional meetings have been going. As of today, we have held three of the five meetings in the Western, Capital and Long Island regions, all of which have been very well attended, as you can see by the data on the slide. We have also received positive feedback from participants on how the meetings have helped to build partnerships and further inform implementation of the prevention agenda during this cycle and in planning for future cycles. We're looking forward to continuing this important convening work in the Central and Westchester upcoming regional meetings. Thank you to the Public Health and Health Planning Council for your support and leadership of the Prevention Agenda work in New York State.

Ms. Dawson With that, I will turn it over to Sue Ellen Wagner to present some of the findings from the informational needs assessment that was part of this project.

Ms. Wagner Thank you, Grace.

Ms. Wagner Good morning, everybody.

Ms. Wagner Grace, if you can go to the next slide.

Ms. Wagner As Grace said, I'm going to be providing some of the information on needs assessment data at a glance, talking about some of survey findings that we've put together and then some key themes and some preliminary recommendations.

Ms. Wagner Next slide, please.

Ms. Wagner The information on needs assessment was to assess some opportunities and gaps in the prevention agenda 2025-2030, and we held some regional events. We've got a few more left, resources training and technical assistance. There were 252 responses analyzed from folks that took the needs assessment. As you can see, there were 232 complete needs assessments and 20 that were partially completed. The audience was local health departments, hospitals, community-based organizations, some state agencies, and other partners. That survey was opened from August 17th through September 18th. There was one response requested per organization. As you can see on the right part of the slide, all sixty-two counties were represented and fifty-one of fifty-seven local health departments responded.

Ms. Wagner Next slide, Grace.

Ms. Wagner I want to talk about some of the key findings that we've looked at so far. Again, 252 responses from organizations serving all sixty-two counties. 92% indicated that their partnerships are established, but under-resourced. Again, they've got really great partnerships in place, but they're under resource and need some joint funding. And that was one of the top requests of the health department to provide some extra help and funding. Fifty-five percent of the CHHA and CHIP guidance needs clearer direction, again, information more needed in terms of primary implementers and just more guidance in general and quicker guidance. 95% of the health equity practices are widespread, reported at least one practice funding dedicated to community engagement was the top request. 30% of resources are valued, but awareness is uneven. So, some folks, a lot of the community-based organizations did not know the Prevention Agenda Dashboard existed and even though there were about three or four users found it easy to use. So, easy to us, but definitely undervalued. We need to do more education on that. The number one finding at a glance was capacity is the most common constraint. Again, that limited funding and staff time were reported as top barriers in every area. Their partnerships, the data, the health equity training and engagement, and then 75% of the partners want practical, flexible support. They really prefer some prefer live virtual training. About four in ten found communications too infrequent, and most want monthly or quarterly updates. Again, more face time, whether it's via virtual or in-person needed to help them... You know, get the results they need for the prevention agenda.

Ms. Wagner Next slide, Grace.

Ms. Wagner In terms of respondents for some characteristics, there were no notable sector gaps, which I think is great. 252 indicated a broad statewide reach. So, responses, again, covered all of the counties. Like I said, fifty-one out of fifty-seven local health departments and at least one responding hospital in every county. The response rate was great. 45% said that primary implementers were well represented, meaning the local health departments, hospitals, community-based organizations were that next largest group at 18%. 62%, mostly local, geographically varied, serve a single county. And then some samples spanned urban, suburban, rural, and New York City settings were led by the Metropolitan area, 31%. A good group participating there. And then 48% said that work spans multiple domains with most often healthcare access and quality being one of the top ones and that social and community context being the second largest focus.

Ms. Wagner Next slide, Grace.

Ms. Wagner In terms of partnerships, 90% said that they partner with four or more types of organizations, which I think is great. We want broad partnership participation and 92% partner with community-based organizations, which is another key goal of the prevention agenda. 92% were engaged and satisfied. They described their partnerships as developing and well-established. Again, something really great. 66% said that funding is the lead barrier, meaning their staff time is limited and they need to have some more resources. They're looking from the health department to support them. 28% most wanted partners are least engaged. They want to engage philanthropy a lot more followed by some local businesses and health plans. Again, those are the partners that folks are looking to engage more with. Lastly, on this slide, 79% of the relationships are driving success. They're citing that regular communication between themselves, and partners

followed by trust built with prior collaboration and existing coalitions. Those relationships that they've had with partners are really key to moving the prevention agenda forward.

Ms. Wagner Next slide, Grace.

Ms. Wagner How the health department can strengthen these partnerships. You know, it all comes down, a lot of it comes down to some shared and joint funding. As you can see, 71% indicated that they need to share more resources and have more funding opportunities. 54% cited strengthening state level coordination and guidance. 46% convening regular cross-sector meetings or forums. That goes back to what I had said previously, whether they're in person, or virtual, and then 43% support joint planning structures or a shared template.

Ms. Wagner Next slide, Grace.

Ms. Wagner In terms of use of existing resources, 75% the CHHA/CHIP guidance is the most useful resource, which is wonderful, but only 55% said it gave enough information to complete their planning. 74% of the users rate the dashboard favorably. Again, really great. 30% said the dashboard's reach is uneven. Some folks don't know about the Prevention Agenda Dashboard. 58% do use it, and the rural respondents use it most, 49%. 32% indicated that health department feedback was very, was least favorably found on past CHHA/CHIP, and community service plan submission is useful. Respondents really describe long waits to receive it. So, asking for a little bit of a quicker turnaround from the health department on their feedback with the plans that are submitted from the health departments and the hospitals. 11% said awareness gaps persist. There were folks who weren't aware of the prevention agenda resources at all. Two thirds of those were somewhat or very aware. Again, some education needed out there to create more awareness. And a lot of that, I think, was with the community-based organizations that we saw at the regional summits.

Ms. Wagner Next slide, Grace.

Ms. Wagner What makes social determinants of health difficult? There were some open-ended questions that the needs assessment took into place and sixteen respondents who found it difficult to address these social determinates of health and either the CHHA, the CHIP or the CSP process were asked why. As you can read on the slide...You know, some of the drivers are outside of their local control, such as housing, poverty, wages, transportation. Six indicated no dedicated funding or staff, so that social determinant of health work lacks dedicated funding, or staffing. Five of them said that their partners don't see the social determinants of health as their role, so it's difficult to engage partners if they don't see that they have a place to play a stake in the game. Four said the framework doesn't really fit local priorities. And then on the right-hand side, it's a quote. I won't read all of it, but... Basically, local health departments have very little control over social determinants of health. That's why I think we need collaboration. Those local health department and hospitals need to continue to work together and engage community-based organizations and others to help them through the prevention agenda 2025-2030.

Ms. Wagner Next slide, Grace.

Ms. Wagner Some key findings on health equity. 95% said that health equity practices are widespread. They're reporting at least one practice and then 79% reporting two or more. 60% are saying that capacity is again the main barrier due to that limited funding and

staffing that I've mentioned before. 78% said funding for engagement is the top request. So, everyone needs more funding, whether it's money or staffing resources. 29% said the formal frameworks are less common using that formal health equity framework, such as the health equity guide or health in all policies. 49% said that trust with communities is moderate to high, which I think is great. They're rating trust with their communities in that very high area, which again, I think is a really good thing.

Ms. Wagner Grace, if you could go to the next slide.

Ms. Wagner Some barriers cited to the health equity process, a practice again, similar to what I've mentioned before, a limited funding or staff capacity, 60% indicated that as a barrier. 38% said lack of staff training and expertise is a barrier, and then 26% said lack of disaggregated data is a barrier.

Ms. Wagner Next slide, Grace.

Ms. Wagner The New York State Health Department support community trust and inclusion? More than three quarters of the respondents indicated that they want funding or resources dedicated to community engagement, and over half really want those community voices elevated in some type of a state level planning.

Ms. Wagner Next slide, Grace.

Ms. Wagner In terms of key findings regarding training, 53% want training on evidence-based interventions. I think that's been a request of folks for quite a long time, followed by the Prevention Agenda Dashboard, and then some grant writing and sustainable funding. 75% say they prefer live virtual sessions, followed by some online modules and written guidance documents, and then 67% site lack of time or staff capacities, followed by scheduling conflicts and not knowing that training exists. Again, I think enhancing the communication out there in terms of resources that are out there and offering folks to network is important.

Ms. Wagner Next slide, Grace.

Ms. Wagner Key findings on communication and engagement. 69% said they want funding and resource opportunities. I sound like a broken record, but that's what everybody is citing. 46% said they prefer monthly updates, and 38% prefer quarterly. Again, enhanced communication. 41% slight lack of staff time to engage, followed by unclear expectations and unclear points of contact. And then finally, 39% of the respondents said that they consider current prevention agenda communications too infrequent. Again, you're seeing some themes and I'm being a little repetitious, but the themes are very apparent.

Ms. Wagner Grace, next slide.

Ms. Wagner Engagement barriers and convening topics. You know, you can see again, it's the same things I've been saying, the lack of staff capacity, funding, unclear expectations.

Ms. Wagner Next slide.

Ms. Wagner Some key theme across the assessment that came through. The number one is the capacity, is the constraint behind nearly every barrier. Again, I sound a little bit like a broken record, but funding and staff time top the barriers. The second, different groups need different support, so some better tools and resources needed that support partners to create more awareness and connection. 55% t of those completing the assessment said that CHHA/CHIP process can be improved. 30% say resources are valued, but they're not reaching everyone. I think making sure that some of these resources are reaching some of the partners such as the community-based organizations, faith groups, and others. 28% said that there are gaps with sectors that hold the resources. Some of those core partnerships are in place. The opportunity is funders, health plans, housing and business. Obviously, again, philanthropy is that top desired partner.

Ms. Wagner Next.

Ms. Wagner Some preliminary recommendations that were taken from the three summits that have been held so far that Grace talked about earlier. Number one, direct resources to partnership and community engagement capacity. Again, that's that funding opportunity that everybody needs. Closing awareness gaps for existing resources, having some type of monthly communication, whether it's a monthly digest, a searchable repository for resources. Some onboarding materials would be great. Streamlining that CHHA/CHIP process, having earlier, clear guidance and timely feedback is great, and then replacing that Excel template. Number four, to expand access to disaggregated data and build data skills. So more disaggregate dashboard views are preferred and having more current data and then training on data, how to use it, how to work with it, and how to interpret it. The fifth recommendation is to design some training around their partners' limit to access again whether that's some virtual sessions that can be recorded and on demand plus some toolkits and some peer learning. I think it is a really great idea. Creating some structured opportunities for connection and two-way input. The regional convenings, I think, were really helpful and highlighted several ways of communicating between the local health departments, hospitals and community-based organization, having some partnership matching and some outreach to underrepresented sectors. And then lastly, tailoring support by region and community type. So, having some region-specific summaries to prioritize funding, training, awareness and data support. That's the end of the presentation.

Ms. Wagner Joe, turn it back over to you for any questions.

Mr. Waldenmaier Thank you, Sue Ellen, and thank you, Sarah and Grace, for going over that.

Mr. Waldenmaier I just wanted to point out a couple of things that they highlighted, because I've gone to all but the Long Island one, so I missed Dr. Eisenstein and Dr. Boufford. The dashboards have come up. You know, the awareness of prevention agenda as a whole is something we are really looking at, and you'll hear more about that on our upcoming December 16th meeting of some of those efforts. I did want to say that we do have the Office of Science going out and doing trainings across the state with the primary implementers, the prevention agenda, the local health departments and hospitals have really given a lot of positive reviews for and helping kind of do the monitoring for the prevention agenda and looking at how they're going to assess their own efforts at the community level. As well as, like I said, we are really trying to push out, I did represent DOH at a recent panel at the Immunity Alliance Conference, which is with over 200 mental health and substance abuse organizations. They loved hearing about the prevention agenda, but they were very clear. They needed to know more, and they didn't know much

about it until I got there. So, definitely an area we're going to try to work with that group as well to keep getting the word out. I did want to point out that we are having some of the Ad Hoc committee members come to the regional summits as well, which has been really great, especially because it's been a number of the state agencies. Again, I think those state agencies' representatives, I know aging has been there. Transportation was at one of them. We really are getting them to be able to hear directly from the local health department and hospitals, which of course is also the point of the Ad Hoc committee. With that, I did want to just show some early analysis, but I will open it up first to see if there's any questions or comments on the regional summits for the NYSACHO team.

Dr. Boufford I just have a quick question for Sue Ellen, because when she was at HANYS, she had been a major force in collaborating with NYSOFA and others to provide technical assistance. And maybe just talk a little bit about, I know you're not there any longer, but that environment. I think we have a new executive director at HANYS who has public hospital experience, which is really. Important and, you know, NYSOFA Department of State had really provided funding for the technical assistance and support, maybe just to remind people of that, Sue Ellen, if you wouldn't mind.

Ms. Wagner Sure.

Ms. Wagner Well, first of all, you know, I've been out of the working for HANYS now for six years, but I have seen a lot of, you know, increased collaboration and partnerships between the local health departments and the hospitals and then seeing a lot of community-based organizations wanting to participate. I think that's great. Again, I think... You know, improving communication out there and involving other state agencies is a great way to engage more community-based organizations. HANYS definitely continues its work on the prevention agenda with its regional associations. I know the Greater New York Hospital Association as well. Again, some themes that are reoccurring from back when I was working on this is that the data, needing more training and help with the data and understanding the dashboard. You know, I think it's great that these regional summits are being held to engage folks together to understand a little bit more about how they can work together is great. I think the health department has been really supportive and has a great team behind the initiative.

Dr. Boufford Thanks very much.

Dr. Boufford I wanted to mention one other associated issue that had come up at the regional meeting that Larry and I attended was this issue. As many hospital systems have sort of gobbled up local hospitals, the governance arrangements are quite different from system to system. One of the areas, and it was actually thanks to an invitation from Sue Ellen back in the day, everything, as Liza said earlier, everything's longer ago than you thought it was. I remember mentioning to the HANYS annual trustees retreat, many of the local hospital trustees are, in fact, the businesspeople in the local communities. They were quite interested in having a role, really, because, as I said, in some systems they don't have much of a fiduciary governance role any longer. Some subset do, but not all of them. They were all quite interested, potentially, in engaging with local health departments, having their hospital leadership understand that they could bring the private sector in their communities into these conversations. I think it's one area to mention that may be in hand in the community rather than having to even go up. We invited the business council. They haven't showed up yet, but we're hopeful. We're trying to engage them at the state level. Anyway, Mark, let me ask you to continue so we can have a full. I'm sorry. Larry, please.

Dr. Eisenstein Thank you.

Dr. Eisenstein Mark, I'm asking this question now, not expecting you to answer it, but you're about to do an analysis and data. You know, one thing that I think makes it difficult for public health is we have a lot of initiatives that the intent is great, the people doing the work are great, conceptually it should work, but we don't necessarily define our objectives well for people outside of public health to understand. To me, the Medicaid waver is a perfect example. I keep asking... What does success look like in the waiver? We're screening. We're screening. We're navigating. We're referring to people. What is it that we're ultimately defining? If you ask this room, everybody has a different perspective on whether it's going well or not. With the prevention agenda, if we want to be successful outside of the room of people who understand public health, I think there needs to be defined objectives and deliverables to say, this is what we're trying to do. Are we trying to decrease diabetes by 5%? Are we trying to lower the rate of smoking? Kind of along the lines of the Healthy People series has historically done with objectives. But without, and this is something that somebody brought up at a comment from the meeting the other day at the regional meeting that I've always thought of, but until I heard it expressed that way, I said, that's something I have to bring up at the PHHPC. My question, and I don't expect an answer now, but it's going to hang out there and I'm going to keep asking it... What is success with the prevention agenda? How are we defining success? What does it look like? If we don't achieve it, then the next cycle we need to fix it so that we can achieve it. Because the people who mean well and do the work are going to try, and the effort's going to be there whether the resources are there or not, obviously that came up on the needs assessment. I think we have to hold ourselves, the public health community accountable for making sure that we're not just doing work, that we're having defined objectives that we can reach. If for whatever reason we're not, we need to evaluate why and come up with a different process. Just my thought.

Mr. Waldenmaier No, thank you, Dr. Eisenstein.

Mr. Waldenmaier We do have objectives within the prevention agenda, but I think you're looking at kind of the bigger, the overall objective, the success, as you said. That is something I think we are trying to build more and more to with the regional summits and hearing from the LHDs and hospitals what they think are their successes. You also kind of set me up a little bit because. Dr. Boufford really has been wanting more and more analysis done, and we are working really hard on data analysis. Dr. Alaali's team has been doing this nonstop for months at this point. We're only going have high level priority analysis here, but this is only meant to set the stage and kind of plant the seeds for you all to think about where we can go next, especially working with the Ad Hoc committee and the social determinants of health with the priorities across the state and what we're seeing just with a very simple analysis of what we're seeing of those priorities with our local partners. I will get into it just for a matter of time. I'm going to go through pretty quickly. But first off, this was something I had shared before, and most of what you're going to look at with this initial analysis. We're focused on the plans, the 116 plans as kind of the denominator. Those 116 plans do represent all fifty-eight local health departments and 190 hospital systems. We do have submissions individually, which you see is twenty-five individual LHDs and sixty-one hospitals who just did individual plans, but we also have thirty joint plans. If you add those up, they don't quite all look together as well as we'd like to. I'll also send this out, although it is posted on our webpage. Just to give an example, we do have to help with our annual progress reports with all the partners, a list of all the submitters, and then kind of the joint plan group. This is a good example of them, Genesee, Orleans, and Wyoming counties. Not only does this plan, this joint plan

represent these three counties, it also represents the three hospitals also listed there. Again, when you're thinking of these 116 plans, it is representing all of the group. So, just keep that in mind. This is all based on those 116 plans. Again, as Dr. Boufford mentioned earlier on, the hospitals submitted more in December, but this was a real change in cycle and just like we've all dealt with different aspects of our work, we've had a lot of staff transition in both the hospitals and the LHDs. Although the ultimate date was in December, it did take us a while to get all the plans submitted working closely with the hospitals, as well as then the local health departments had their assessments due in December and then their plans due this Summer. The joint submissions, some of them with even the local health departments got them in early in December and some of them did not get them in until the Summer. For what we looked at initially that I'm going to share with you today, there were the three major submission requirements which were the assessments itself, then the plans, and then we also asked them to fill out a work plan, which was basically an Excel document that kind of summarized some of the key information, the priorities, the social determinants of health, the objectives and the interventions that the local partners had chosen in order to support the prevention agenda as a whole. So, that's kind of my caveats for what I'm about to show you is this early analysis is just based on those work plans. We've already seen through having to clean the data of the work plans where sometimes things were put in accidentally, sometimes things were putting wrong. Part of what Dr. Alaali's team has really worked really hard on, and they've worked with all four of the DOH regional offices to review not just these work plans, but the assessments and the actual plans as well is kind of validating all that data, making sure that what our final analysis will be more accurate for what they actually have down in their actual plans. Also, this analysis only looks at the state identified priorities. Remember, each of the local partners per requirement had to pick at least three of the state-identified priorities, and then they could develop as many of their own as they wanted to. If they wanted only to do three state priorities, that would be it. If they want to do three state and ten local, they could do that. They do have a large range, but we're only looking at the state, and that's especially important when we think about the social determinants of power. We look at the early analysis of that because those local priorities are going to be done in the fuller analysis, and they may kind of sway some of the direction, especially of kind of that high level domain or social determinant health. Along with that fuller analysis, we do have some geographic distribution that I'll be sharing with you before we get to the next December 16th meeting. This is just a quick look at those five domains or social determinants of health. One of the big reasons we want to really work very closely with all the organizations and agencies in the Ad Hoc committee. You'll actually see, and this is where I think, as we get the full analysis, you might see a little sway, especially because the three areas are so close that healthcare access, economic stability, and social and community contacts. We're where a majority of all the priorities across the 116 plans fell. So of course, as we know, Department of Health has a lot of focus and empowerment and healthcare access, but when we're looking at economic stability in social and community context, we're going to really have to partner with some of our other state agencies and a lot the other statewide organizations to really try to make an effect in those priorities and objectives within the prevention agenda.

Mr. Waldenmaier This is kind of the key slide. Again, we only looked at the Excel work plans for this, but we were able to identify the top priorities at least. The top five I'm very confident of, the lower five, start getting so close numerically that again, if there were some errors in the Excel Work Plan, we may see where we get a little shifting and of course like number six and seven are the same exact number anyhow. It's kind of arbitrary that they're in that order at this point. Again, hopefully that will be nuanced out with the full analysis, but we do see where we have some of the top five. And for those of you who have gone to

some of the regional summits, I have been mentioning these top five because it is really important in looking at the prevention agenda as a history. Because as we know, the prevention agenda is in its fourth cycle, and the last cycle was structured very differently. We did not have the social determinants of health as strongly involved. We did have twenty-four priorities. We had a lot less priorities. So, trying to compare across the two different ones is going to be very hard. That being said, some things I wanted to just highlight quickly today is prevention services for chronic disease. Chronic disease as a whole is our number one. That was basically number two in our last cycle as well. You know, even though, as we know... Department of Health deals with a lot of infectious diseases. The prevention agenda as a historical program kind of started around the time of the H1N1 pandemic. This cycle was coming out of the COVID pandemic. We know how much impact they have on DOH and the local health departments. But at the same rate, those chronic diseases still end up for two cycles in a row being part of that top five. Nutrition security is one of the big ones were again, that's whereas a priority, as one of the social determinants of health, we're going to have to work with a lot of partners. That being said, we know our Commissioner actually has nutrition and security as one his focuses as well for the department. It's such a critical topic that we're going to look at. I know Dr. Whalen put a link in the chat even about nutrition as medicine and these other aspects that again, we're already doing some cross-agency work, but we want to do more in order to tie it to the prevention agenda. And then rounding off the top five, it really is all more mental health focused, and they were kind of bucketed in the last prevention agenda cycle as only a singular priority. So, that's where we did. I know it was mentioned. OMH, OASAS, Dr. Ali worked very closely, Dr Whalen worked very with those agencies in the development of our state health improvement plan, and obviously the results we're seeing from our local partners means we're going to have to keep working closely with them and keep working even more in an active way in order to try to make progress with these prevention agenda priorities.

Mr. Waldenmaier On that, I did want to kind of move into a little bit of the talk of interagency before I ended, just because we don't have a lot of time left. Again, this is where really hoping to get a lot feedback from you all on the December 16th meeting now that we have more of this data, and you'll see more of it in the 16th. What are some of the ideas? What are some organizations and agencies that we really should maybe target for really committing to working with more closely? I will reshare the Ad Hoc committee organizational list. I know that was sent out, the point of contact list recently. But I know my own work and going to the regional summits and hearing from the local partners, housing and transportation has really come out as well. We see some of those top five priorities. We see things like mental health or maybe Ag and Markets for nutrition security. That's all going to be needed for us to keep moving forward. I'll actually end at this point because I did want to at least give a few minutes to make maybe any initial reactions or initial comments. But as well, I know we want to pass it off to Bella and hear about the recent community benefit reporting efforts. I will stop there and see what people want to say. Remember, we do have December 16th where prevention of agenda will be a much bigger focus.

Dr. Boufford I think it would be a good idea to re-circulate to the committee the members, the agency members that have been part of the Ad Hoc committee, and as I mentioned, the three that were there the first time presenting, and the idea was that in the Ad Hoc meetings each of these agencies would have that opportunity. So, just to remind everybody, the partners we do have, and the partners may not have. Again, the Ad Hoc committee is state-level, professional associations, advocacy groups, other agencies and sort of non-profit. The idea of the Ad Hoc is they then communicate with their local and or

regional divisions, directors. The New York State Health Plan Association, HANYS, Greater New York, they're all part of the Ad Hoc group with the idea disseminating. So, as was mentioned in the report from NYSACHO, this information, you can't ever repeat yourself often enough when you're trying to get people who don't do this all the time to think about it. It continues to be a challenge. Thanks, Mark, very much.

Dr. Boufford Any other comments, questions from colleagues?

Dr. Boufford Let's move on, because the community benefit, we hope maybe, we have a goal with this alignment with the community-benefit process. Again, I want to remind everybody as we start, we had, this came up again in the regional meeting from the Greater New York Hospital Association, and we do not in any way deny the fact that the hospitals in the state of New York provide significant community benefit in terms of unreimbursed care, graduate medical education, other issues. That is not what our focus is. Our focus, we want to hear about that, but our focus on one category called community health improvement. That's a small category. We have the data about it, and we want to see whether it can begin to be aligned with evidence-based interventions in alignment with the preventionist.

Dr. Boufford Bella, over to you, please.

Ms. Elogoodin Thank you so much, Dr. Boufford.

Ms. Elogoodin Everyone hopefully can hear me. My name is Bella Elogoodin. I'm very, very happy to be here and present the information related to first statewide community benefit information.

Ms. Elogoodin Let's start at the beginning.

Ms. Elogoodin Next slide, please.

Ms. Elogoodin Was what community benefit actually is. We're going to move to the next slide right away.

Ms. Elogoodin Community benefit means the activities and programs hospitals subsidize for the express purpose of improving community health services that don't generate inpatient and outpatient revenue. Though there may be a nominal or sliding scale fee in plain language, it's the work hospitals do to make their communities healthier beyond their four walls.

Ms. Elogoodin Next slide.

Ms. Elogoodin Hospitals invest resources beyond direct patient care through a range of community benefit activities. Statewide reporting gives us a clearer picture of where those resources are being directed and how spending varies across communities.

Ms. Elogoodin If we go to the next slide, that slide will give us a quick overview of New York's community benefit reporting law. The law took effect on October 1st, 2025, and requires nonprofit and public hospitals to report the community benefit spending and activities to the department. The goal is to improve transparency, better understand how hospital resources support communities, and look for patterns across hospitals and different benefit categories, including also the regions too.

Ms. Elogoodin If we go to the next slide, you can see everyone has a part to play. Hospitals track and report their community benefit activity and spending and submit it annually. And just to remind everyone, this is just the very first year, the Department of Health collects and compiles the data, builds the reporting tools for guidance, publishes, that's eventually, given that it's the first year and our state partners and stakeholders use this information to understand trends and community needs.

Dr. Boufford Can I add one preliminary thing that I think I don't think you're covering? This is really important to get to the specifics for New York State. Community benefit reporting is required of all nonprofits to the internal revenue service, because it provides them justification documentation for those tax exemptions They don't pay real estate taxes, income taxes, or any other. As it happens, the hospital sector in the US is the biggest. It's called Schedule H IRS. I think makes it, in New York State adds a level of specificity that's going to be really important going forward. Thanks. I just wanted to throw that in there for those that haven't been involved.

Ms. Elogoodin Absolutely. Thank you so much, Dr. Boufford.

Ms. Elogoodin If we go to the next slide, we can see what exactly hospitals are reporting. The eight categories, financial assistance, unreimbursed Medicaid and other means tested program costs, community health improvement services, health professions, education, subsidized health services, research, cash, in-kind contributions, and community building activities. Together, these capture the full range of how hospitals invest in the health of their communities.

Ms. Elogoodin If we go to the next slide, the mechanics are simple by design. Non-profit, as Dr. Boufford said, nonprofit hospitals complete their reporting. W utilized the survey management and response tool. Nonprofits submitted their most recent IRS Form 990 Schedule H, where public hospitals report through that same survey management and response too as well. The department then compiles, analyzes submission, and publishes the state annual report.

Ms. Elogoodin If we go to the next slide, we can see, even in this first cycle, so if we go the next slide, please.

Ms. Elogoodin Yes.

Ms. Elogoodin Four big lessons are also emerging here. First, community benefit goes far beyond financial assistance. It spans a wide range of health and public health activities. Second, reported spending varies across hospitals and regions. Third, context matters. So, person served, programs offered, and net expense tell us things total dollars can't. Fourth, this report establishes our baseline, the starting point for tracking and strengthening consistency year over year, given that this going to be our baseline.

Ms. Elogoodin If we go to the next slide, that sort of establishes our annual reason starting this year. Throughout the year, hospital track their community benefit activities and expenses. By July 1st of every year, their reports are due to the department. Over the Summer, we in the department complete and analyze the data, and then we publish the statewide report. 2026, again, as I mentioned 150 times is our very first cycle under this law.

Ms. Elogoodin If we go to the next slide, crucial slide that shows the statewide total, $71.2 billion in reported community benefit expenses. New York City hospitals account for $42.2 billion of that. The other six regions together account for about $29 billion. Individual hospitals amount ranged from $582,000 to $7.2 million. The New York City share lines up with the city's share of the state's population, hospital beds and hospital spending.

Ms. Elogoodin Going to the next slide, we will look at where the dollars concentrate by category.

Ms. Elogoodin Let's go to the next slide, please.

Dr. Soffel I'm sorry. I have a really quick question, which is when you say the hospital-level reporting spans a wide range... Are individual hospitals or are hospital systems considered as a single entity?

Ms. Elogoodin So, hospital systems, depending on their operating certificates, some of them are standalone and some of them are part of the health care system.

Dr. Soffel It makes it much harder.

Dr. Boufford Each one has a different government structure.

Dr. Eisenstein And if I can clarify that, it's actually done by TIN number. You could have a whole system of hospitals, ten, twenty, I'm making this up, but you could twenty hospitals under one TIN number and one serves all Medicaid patients and other serves no Medicaid patients, but it's aggregated in one average, whereas another system where each campus has its own TIN number will stand out uniquely. That to me is one of the major problems with interpreting this kind of data. It's not apples versus apples.

Dr. Soffel Will that be broken out in the actual report so that we can see when it says one hospital spent $582,000 and another spent $72.2 billion? We will know who each of those are.

Ms. Elogoodin We will eventually, as we're strengthening and we're getting the reports back year over year, we will be able to make sure that we have the compilation of the data too. Good point that you're making it and thank you so much for explaining it, Dr. Eisenstein.

Ms. Elogoodin So, if we look at this specific slide at where the dollars concentrate by category. Financial assistance, free or discounted care for eligible patients totaled $3 billion statewide unreimbursed Medicaid costs came to $11 billion in net expense after direct offsetting revenue. Subsidized services and services hospitals provide at a loss because the community needs them totaled $4.8 billion net, against $13.9 billion in total expense. One more nuance here, the average hospital reported share of spending on subsidized health services was highest in Finger Lakes at 6.5%, followed by the Hudson Valley at 5.2%. A quick caution as we go, sections show totals before offsetting revenue while net figures deducted. You will notice New York City shows a negative figure of about $209 million for other tested programs. That's a calculation item from offsetting revenue reported without matching expenses, not a financial gain. We're working directly with hospitals to tighten consistency in future cycles.

Ms. Elogoodin Let's do the next slide.

Dr. Boufford Before you leave this slide, we want to highlight the upper left-hand corner, 0.88% is the current investment of all of the community benefit funding for what we're calling community health improvement. It is by far the smallest. One of the other areas of interest, thanks to a doctoral program, doctoral thesis at SUNY Albany with a colleague who had been working on the health department. We know these categories by hospital across the state for the last seven to eight years. This pattern, the 8.8 is a little bit higher than the last time we saw it, but not much. That's what we're looking for here, and that amount of money is something that ideally, if it were aligned with hospital commitments in their committee for Prevention Agenda with their local health departments, et cetera, we could have additional evidence-based investment and perhaps more sustainable investment in these areas and begin to see community benefit in the public health area. I just want people to realize that's the part we're talking about here is the 0.88

Ms. Elogoodin Thank you so much, Dr. Boufford.

Ms. Elogoodin It's good, like I know it's first year, and we're going to strengthen our report and compilation as we go forward and work very close with all the hospitals around to ensure that we have the information and also align with prevention agenda as well.

Ms. Elogoodin If we go to the next slide, a quick map of what counts as community benefit. A little bit, if we back to what counts as community benefits, the categories in this section.

Ms. Elogoodin Oh, we did.

Ms. Elogoodin First, financial assistance. Free or discounted care for patients who can't afford to pay and meet the hospital's criteria. Statewide, that's three billion. New York City accounts for about $1.97 of it, with Long Island next at roughly $372 million and the Hudson Valley at about $254 million.

Ms. Elogoodin Next slide on the reimbursement cost for Medicaid. After direct offsetting revenue, hospitals statewide report $11 billion in unreimbursed Medicaid costs. New York City leads at about $5.56 billion, followed by Long Island at roughly $1.86 billion, and the Hudson Valley at about $1.54 billion. This is the net figure, the cost remaining after Medicaid payments, and it reflects a coverage gap, and is one of the largest categories in the report.

Ms. Elogoodin Next one.

Ms. Elogoodin This is the category closest to what many people may picture as community benefit. The program themselves, health education, screening, outreach, and the operations behind them. New York City reported about $511 million, with Long Island at roughly $98 million, the Hudson Valley at about $84 million, and Central New York near $67 million.

Ms. Elogoodin And the next one, which is the training tomorrow's clinicians counts too, as we mentioned here before in various different presentations, medical students, residents, fellows, nurses, and allied health professions. New York City reported about $6.7 billion, reflecting its large concentration of teaching hospitals, with the Hudson Valley next at roughly $1.26 billion and Long Island near $900 million. This is a major driver of the

statewide total. Educating the healthcare workforce is itself an investment in community health.

Ms. Elogoodin Before we close, a word about the kinds of program behind these numbers. The report includes examples, as we looked at it, from every region of the state. They show the range of what hospitals are doing, connecting patients from the emergency department into addiction treatment and recovery support, with peer support and follow-up after discharge, school-based health centers, support for mothers and newborns, lead poisoning prevention, training programs that build the local healthcare workforce, and planning and infrastructure that keep care available during emergencies. The mix looks different in each community because hospitals are aiming to support what the local areas are in need for. So, that's the picture behind that totals. A wide range of local programs reported consistently for the first time this year. As we are continuing to look at the information and looking into strategizing on next steps, we would like to ensure that we have more details in that. This report is just in the beginning. It's not an end. A baseline-building partnership between all the hospitals in New York State. Thank you so much for listening.

Dr. Boufford This is great. I really thank you so much for this. Doug Fish, I wanted to give you an opportunity. You might want to add something before we move to Q&A. This is very impressive to get this information all submitted at this level of analysis at this point in time. Thank you.

Dr. Fish Well, thank you, and thanks to Bella for presenting it. You know, it's been a long time coming, and just thanks to all of you for the support to help us get there and to help us be able to get the legislation so that we can do this. It's a lot of data. We tried to distill it down to kind of what would be meaningful, and as Dr. Boufford mentioned, it is the community health improvement. Community benefit piece that is most of interest and is the smallest portion of the pie that you saw there. Yet, hospitals are doing a lot. When you get down to individual facilities, the data is relatively meaningless because it really depends on the size of the facility, as Dr. Eisenstein said by their facility identification number. You know, you don't really we don't have denominator information to inform and make cross comparisons. Some of the raw data is less helpful than one might and one might think. It is reportable to the IRS as was pointed out for all non-for-profits for the public benefit corporations. This is a heavier lift for them because... You know, they don't report to the IRS and the team worked with them to get that information. Again, this is year one. We're all still learning. There's a lot, I think, still to come as we continue to pour through the data and work on getting a meaningful report out.

Dr. Boufford Thank you.

Dr. Boufford Questions from colleagues?

Dr. Boufford I think Mr. Lawrence had his hand up first, then Dr. Watkins.

Dr. Boufford I mean, I'm sorry, Dr. Wilcox. Dr. Watkins isn't here today.

Mr. Lawrence One of the things that I've struggled with being on the committee here is this whole notion of individual hospitals. When you say that the data at the local, at the individual hospital level is really you can't claim much from it... Is there any way of developing a benchmark that you can look and do a comparative review of the hospitals,

how they're doing against each other in terms of community benefits across these indicators that you have articulated in the aggregate?

Dr. Fish I'll take that and then others, Bella or Jackie, feel free to jump in. Because we don't have denominator data, you know, in terms of... They are the size... You know, in the report of the facility and what their total data is facility comparisons become really unreliable and impossible. What the report collects is kind of the raw data. We're still thinking about this question and trying to better understand how we could present it. We're right now don't have a solution to that based on the data that's collected and similar data that is collected in the Schedule H 999 forms.

Ms. Sheltry Hi. This is Jackie Sheltry, Department of Health. I agree with everything Dr. Fish said. The only thing I would add or expand on that is that we are very interested in, like Bella said, this is the first year of reporting in looking for the future of what years two, three, et cetera will look like in terms of what kind of meaningful comparisons we can make. As Dr. Fish articulated, that might not be a facility-to-facility comparison, but whether it's at this meeting or future ones and in other stakeholder engagement, we are interested in collecting feedback on what types of comparisons, metrics would be useful for the community at large, whether that's hospital community or patients, et cetera, community-based providers. So, that is something we're actively starting to think about, and I think after this meeting, we'll start to continue and talk about what that looks like again, in terms of what we're comparing, whether that is regional or facilities, et cetera is definitely something we are still continuing to explore and discuss internally.

Dr. Boufford If I could just add one thing before going to Dr. Wilcox, a couple of things. One of them, I think, is at an earlier meeting of this committee, we had played around with some suggested language that might have been used. I think it was especially for a questionnaire for the public hospitals, because that was the first that might've been used to have a more granular analysis of the community health improvement category, not the other ones. The other ones are bigger numbers, a little bit easier to do. I think we sort of abandoned that for time pressure and other things. I think one of the questions for us would be... What might that language look like in another round of requests of the hospital? Just for that category, again, because I think the other thing I was going to say associated with that, when I was at the New York Academy of Medicine, we had done a couple of studies of community benefit with colleagues in Wisconsin who actually started this whole thing of looking at this source of finances and ended up having to do qualitative interviews with the hospitals on this category because it just isn't... You know, it's not reportable. It's too small. I think that would be a question as to whether there might be... You know I would imagine there might be a foundation that might be interesting. I mean, in New York Health Foundation and others that have been in this space in trying to help sort of figure out what would qualitative data gathering look like in order to get a little bit more granular understanding of the community health improvement category and how it might be better aligned with the prevention agenda and with investments in community health. It's a really important question, Harvey, that you're raising.

Dr. Wilcox So, first of all, thank you. This is clearly a lot of work, and so really appreciate you putting this together. This is a question on the two graphs, financial assistance at cost and unreimbursed costs for Medicaid. It's no surprise to me that New York City would be, you know, two to three times as much as everyone else. Population-wise, that would make sense. Would it be helpful? This is really genuinely just a question to break this down per recipient so that then we could compare region to region and then population size wouldn't be as much of a factor and we could genuinely see in terms for this cost expense how

much is going like to a person individually? Would that make sense? I don't know if you can help me understand.

Ms. Sheltry If I'm understanding you correctly, you're talking about adding like almost like a per capita? We honestly did talk about that, but just a few days ago. It wasn't ready in time for this report, but it is something we're internally looking at and may be helpful.

Dr. Eisenstein Sure.

Dr. Eisenstein You know, we started this conversation, Dr. Boufford, talking about the category specific to community health improvement. You and I have discussed ad nauseum as public health professionals for life that we would like to see that category increase. I still agree with that. My comments are meant to be productive towards that. Let's look at what was just presented. Hospitals in New York State in one year report $11 billion dollars in unreimbursed Medicaid work. That's one small category is $11 billion dollars in losses. We don't even look at unreimbursed Medicare costs, which is also numerous billions, but is not categorized in the rules of this program. We want to see investment in a category that we all think is good public health, but the reality is the C suite see $11 billion in losses just from unreimbursed Medicaid, billions others from unreimbursed Medicare. While I'm all in on we should be investing, the people that determine where the money goes, 75% of the hospitals in New York have lost money. It's very hard to invest somewhere when the bottom line is negative. And until we get to the bottom of... How do we stop these losses? It's an evil cycle because doing the work in the category we want to do would likely lead to losses here. It's almost like we're chasing the tail, but the numbers of $11 billion in Medicaid loss and that other category that Dr. Boufford pointed out, 0.88% is tiny in comparison. And the question is, how can we increase that number, which I'm supportive of increasing while these massive losses are in place? Another thing that makes this complicated across the state is... And perfectly legal and done well are the varying accounting practices. There's nothing in here in the law that says how big a tin should be for a hospital or how small. How about things I know that there are hospitals where some of the work is being done, but it's paid for by foundations. Should we count that work? It's almost like a tax return. You can't get a refund of what you didn't pay in the first place. If the work still being done why should a hospital not be credited? That's something we had talked about. And a lot of this goes down to... You can manipulate the accounting to make it look however you want to a certain degree. I'm not an accountant. I don't know those tricks. The point I'm making is each hospital system is accounting for this differently. You can't even, I very much appreciate Dr. Fish's comments on the denominator and that we really can't fairly compare apples to apples. I wish we could, because it would give us, as I talked about earlier on a different topic, specific objectives. There's also nothing in the law that says we agree we want the category to grow. There isn't a number that legally a hospital has to hit. There's nothing that says it's 2% or 3%. Nothing says it's the valuation of what your property. A lot of people say, well, your property tax benefit is X. You should match that. There's something that says that that's an opinion. One of the challenges that we have again is, philosophically, I think there's a lot of agreement on what we want to boost the area on community health improvement. That's the work I lead at my system. I certainly want to see that category boosted and improved. There's so many varying factors that have to be considered that I just don't want us to rush to judgment about what is or isn't happening without a full understanding of the various factors that lead to these reports. Some reports come out and say this hospital's doing well and that hospital's not doing well in this and whether it's my system or not is irrelevant, never shows the whole picture. There's a lot of these unanswered questions. I'm going to be supportive of any effort along with Dr. Boufford to

try and get that category of community health improvement up, but it's not going to happen in a vacuum without looking at these other categories.

Dr. Boufford I think part of the issue, if I may, is what is being paid for under that category. That is a really important thing. If it's community relations staff for a hospital and it eats up half of whatever the claim is, you're right. There are no standards. I think one of the things I hope will come out of this exercise, if not the next round but the one after that at least is some clarity in these issues because I think the point is that... I may be saying the numbers incorrectly, but I think it was a little shy of $200 million, that 0.88% statewide. And if it's going into, you know, what we're saying, the hospitals are saying they're spending it in that category. The part that I think may be possible with the small category is saying, well, is it aligned with the commitments you made when you sat down with your local health department and the other partners to invest in three priorities of the prevention agenda? Is it something you've been doing for a long time that may... You know, screening programs with no follow-up? I'm just making that up as an example, and many are doing very robust things, but I think that's part of the hope is to be able to begin to get a sense of that because the category is small. You know, and the hospitals are saying we're spending in this area, and it may be that.... Anyway, just too, we're not saying increase is great, but also let's figure out what you're doing with it now and how it could be aligned with what's going on anyway as a first step. I think that's exciting about this.

Dr. Soffel Yeah, I have two sort of observations in response to what others have said, and then I have a question. First of all, as you were reporting on your findings, I was thinking to myself... How do we know how much consistency is in the 990 reporting categories? I know you gave us a 101 on that at our last meeting, but it would be helpful to be reminded of how the IRS is defining these things and how... I mean, how mushy or how clear those categories are, because I think that will help get at some of this thinking. Second, I wanted to follow up on Dr. Wilcox's comment. I think it would be really interesting if we could pull the public benefit corporations out of the regions and have them sort of as that's because I think what we know about H&H will be, and New York City would look, if you pulled H&H out of New York city, it might look quite different. I think that would at least be an interesting exercise to pursue. And my question, for all of us is one of the goals of the community benefit reporting is to increase transparency. I am struggling to think about how we get these findings out to community stakeholders who are going to care, who are going to look at this and say, wow, that doesn't... Is that really what the IRS means when it talks about what community benefit is? I think that these findings and this conversation need to happen at the community stakeholder level because part of the transparency that this law was intended to address needs to happen the community level and not simply around this table.

Dr. Boufford Well, I think two comments. One is the categories are, they are, well, what community benefit means and what counts as community benefit was part of Obamacare. I mean, it's a federal law and it sort of defines those categories. I think the IRS categories are even more granular. I think one of the issues here, and these big bucket items, not in the area that you're talking about. I think it would be incredibly helpful if we had greater understanding. I'm just staying with the community health improvement category because. That is one that doesn't in any way deny the contributions that the hospitals in New York make in these other big-ticket items. Those would be very helpful if your partners around a table on a prevention agenda in your county for people to know what the hospital is spending in that area. Is it aligned with what they have expressed, their desire to see as the priorities coming out of that county and that hospital partnership? So, very, very important point.

Mr. Lawrence I guess my thought and question sort of aligns with some of the points that Dr. Soffel has made and that is... You know, what does it look like when you have a really financially robust and healthy system compared to, say, public hospital system? What do these things all look like, although you can't compare them based on what I stand now on an apple-to-apple basis. How would all of this sort of shake out and look if you're looking at a well-endowed system compared to H&H? What would the profiles be like? Is there any information to be gained from that?

Dr. Fish Yeah, this is Doug. I'll just chime in. I think that is a good question. Thank you for kindly raising it with you and Dr. Soffel. We'll take that back because I think we could look at the public benefit corporations probably as a whole and perhaps by region. It's a very intriguing question and something that I hadn't thought about. Thank you.

Dr. Boufford I also want to emphasize that's a really important question, and I also said the backing out of the publics from this in the geographic area is important. I again want to keep coming back to the idea that what I hope most interested in is a level of information about what hospitals say they are doing in the category that could be invested productively in their local community aligned with the prevention agenda. I mean, it's a different. It's a booth and, but I don't want to lose the notion that here we wouldn't be comparing hospitals with each other because they're in different communities. As one of my colleagues said for a long time, all governance is local. I mean, it's really about who's around the table and people are going to be around the tables differently in every community. That's kind of at a level of granularity what we're interested in because then that becomes transparent, Denise, relative to what is that investment aligned with what commitments have been made to other stakeholders in the community as well as in their hospital partnerships? And if not, I'm sure that it can be moved around perhaps or informed by some of the shortages we've identified that don't exist relative to technical assistance or other kind of technical support. I think to your point earlier about return on investment, I think if we can begin to make these cases more clearly, there are a number of significant philanthropies in the state of New York that would be very interested in supporting the kind of analysis that would help get this done even more efficiently.

Ms. Elogoodin Thank you so much, Dr. Boufford, and thank you for weighing in all your input as we continue progressing. This is the first year, so it was the first exercise. We hope we continued growing and getting the input from all of you, from all the stakeholders. We're going to eventually build a very reliable, transparent system. As Mark said, for the prevention agenda, this is planting the seed as we're going to build more and more with feedback from all of you we're hoping going forward in year two or three or four, as I am being maybe very overly ambitious, my hope is that we will be able to align it a little bit more with prevention agenda and provide a little more information to all the questions that you have. So, that's my hope and thank you so much.

Dr. Boufford Thank you very much.

Dr. Boufford I would say one of the contexts when this conversation began a few years ago on community benefit, some states do, in fact, have a carve-out percentage of community benefit. Massachusetts, for example, has put three percent into a Public Health Fund. For a state that sort of regulates everything, I mean I think New York is one of those highly regulated states in the country. We have done very little in this space. This is a step in that direction, which is really, really important is just to money that's already being spent in a category that could fund what we have been hearing for the last two and a half hours

is a sector that really doesn't have a lot of resources. It certainly doesn't have the resources it needs to sort of move the needle on New York's health overall. These are really important conversations. We'll see you again in December. Again, thank you, Dr. Fish, for your office's collaboration here. It's really, really important.

Dr. Boufford We have a few more minutes before public comment. Any other questions from the council members?

Dr. Boufford Anybody here in public? I see two members of the public, but they may be staff. I don't know if they have any questions or not.

Dr. Boufford Anything from the public any comments otherwise?

Dr. Boufford Anything online?

Ms. Ravenhall Hi. It's Sarah Ravenhall. Am I able to give public comment?

Dr. Boufford You are indeed.

Ms. Ravenhall Awesome.

Ms. Ravenhall May I start?

Dr. Boufford Please do. You're the only one so far that I... Larry was divining from the chat, I guess people that wanted to speak. Maybe he has other people after you, but as far as I know you're it.

Ms. Ravenhall Awesome. Well, thank you, Dr. Boufford. Thank you. This has been a wonderful meeting today. It's great to see everybody, even though I'm not there with you in person. I was really excited about your conversation around public health nurses. I thought while I was listening to the session, I could put something together to give you even a little bit more flavor for public health, nurses working in local health departments, what they do, what the vacancy rates are to help inform next steps. So, public health nurses are essential to local health departments. We know that. What they do is they really link clinical care and community health and help counties fulfill their responsibilities under New York State's Public Health Law. So, the counties have statutory obligations. They have to provide public health services to communities. And without public health nurses, there's no way they can accomplish this work. So, that's a really important consideration. I also want to really emphasize that there were compliments rather than duplicates, hospital and clinical-based nursing services. While clinical nurses focus on the individual patients, public health nurses really bring prevention and care into communities through population health assessment, disease investigation, immunization, service coordination, education, and emergency response. They also do things like supporting planning, evaluation, partnerships, quality improvement and preparedness. This workforce is... You know, the value that they play is really clear as local health departments respond to outbreaks, including the current measles outbreak. Nurses. You know, on the brink of responding to measles right now are meeting residents where they work, build trust, they address concerns, and they promote MMR vaccine. Their unique value is really bringing prevention and protection beyond the clinic walls and hospitals to the people that need it. We are facing a critical nursing shortage. As of 2025, registered nurses in local health departments had the highest vacancy rates among any local health department title or occupation. They have about 695 vacant full-time employee positions statewide. 695

across New York State, including New York City, and their vacancy rate is 40.2%. The gaps that we are seeing in those nursing positions really threaten the departments, the local communities, the ability to meet Public Health Law responsibilities, and also sustain services that protect communities across the state. So, happy to work with you guys on this topic. Public health nurses are our heart at local health departments. Thank you for a wonderful meeting.

Dr. Boufford Thanks very much, Sarah, for your comments.

Dr. Boufford Any other comments?

Dr. Boufford Any other members of the public?

Dr. Boufford Anybody up there?

Dr. Boufford Liza, anybody in the virtual world?

Dr. Whalen Nothing from me. Thank you.

Mr. Waldenmaier Yes, yes.

Mr. Waldenmaier I just wanted to say a big thank you, because as you heard at the start of the meeting, Dr. Zahra Alaali is leaving the Office of Local Health Sciences but staying in the Department of Health. Just a huge thank you to her. She has been such an important transition for our office, for the prevention agenda, working with the PHHPC. She came while we were going from the third cycle to the fourth cycle, while we were going from the COVID pandemic that impacted our entire world into the new world we kind of live in now that I think we can all agree is very different in many ways. She really also was a big transition for I think even Dr. Whalen I know for myself. She has been such a mentor for us in her role. So, her leadership and her intellect were so important for this current cycle, and I think for future cycles of the prevention agenda. So, just a big thank you to you, Dr. Ali. I think the one thing I will say is his intellect is obvious because as we just showed, chronic disease is the number one priority for this cycle, and she's literally going to DOH chronic diseases. Obviously, she didn't even need to do the analysis, she already knew, and he's leaving us to do greater things. Again, thank you so much, Zahra, for all that you've done.

All (Clapping)

Dr. Boufford I'd just like to add one comment which was Zahra was directly responsible for I've been going back even before Mark and Eliza arrived. We even during kovat the hospitals were reporting data for the dash for the Prevention Agenda Dashboard. Nobody thought that would happen. I think part of it was because It was kept at such a high quality and people really saw it as such a resource that they really honored that in spite of everything else they did. I think that was largely because of Zahra's expertise and her professionalism that that was able to happen. I just wanted to add that comment as well. We really appreciate it. Wish her well. It could not be in a more important area than chronic disease prevention.

Dr. Boufford Zahra, you want to say a word or two?

Ms. Alaali I don't know if you can hear me. I was speaking. I just want to say thank you more. I can't thank Dr. Boufford and the committee members. It has been a privilege to work with all of you in supporting the prevention agenda. I will truly miss those meetings. Definitely, I will miss all the challenging questions. You kept me on my toes for the last three years, but I appreciate the opportunity. It has been a learning curve. Thank you everyone, and I hope you continue the great work.

Dr. Boufford Thank you, Zahra.

Dr. Eisenstein Very quick question. Will we have access to the presentations, or do we need to schlep this home on the train?

Mr. Waldenmaier We'll send out all the slides, NYSACHO's, mine, and we'll get them to you along with other documents from today.

Dr. Boufford We do have dates for December for the Public Health Committee and the Ad Hoc Committee. I think we'll take council about whether we have enough analysis done for the Ad Hoc committee to happen before the end of the calendar year versus early in January. We'll come back to you on that but hold those dates. We will be reporting to the council, PHHPC, and I encourage everybody from the Public Health Committee to make as many comments as you wish when we report to the PHHPC at our next meeting. Thank you all very much. Appreciate it. Thanks to staff, Mark and his team and to Doug and his team and Bella and others. Keshana, we have work to do, so we'll look forward to doing that with you. Thanks very much.