Stakeholder Feedback on Prevention Agenda Priorities

Summary

The New York State Public Health and Health Planning Council's Public Health Committee established the Ad Hoc Committee to Lead New York's State Health Improvement Plan in February 2012 to develop the state's plan for public health action for 2013-2017. The group has reviewed data on current health status, discussed progress to date in the current state plan, and proposed a vision, goals, principles and priorities for the next five years. The committee has advanced goals for improving health status in five key priority areas and to close important disparities in those areas through multi-sector activities and actions. The five proposed priorities are: Prevent Chronic Disease; Advance a Healthy Environment; Healthy Mothers, Babies and Children; Prevent Substance Abuse, Depression and Other Mental Illness, and Prevent HIV, STIs and Vaccine Preventable Diseases. **A** goal of the committee is to build on the lessons learned from the previous plan.

Committee members conducted stakeholder sessions with their own organization's and broader community members to obtain feedback on the proposed priorities and on how best to assure continuing involvement of multiple stakeholders in designing and implementing interventions. Committee members organized discussion groups and sought stakeholder input on the existing Prevention Agenda, current health challenges in NYS , and proposed priorities from their members. Specifically, committee members sought answers to four questions:

1. What did communities view as strengths in their experiences working with the 2008-2012 Prevention Agenda?
2. What were some challenges working with the 2008-2012 Prevention Agenda?
3. How can these strengths and challenges be addressed through the next version, the Prevention Agenda 2013-2017?
4. What are key issues that should be addressed in the 2013-2017 Prevention Agenda?

The feedback was analyzed and categorized into comments as follows:

- Inputs related to infrastructure (communication/coordination, partners/sectors, data and measures, financial/policy supports, and workforce).
- Outputs (comments related to specific priorities and strategies to consider for each priority area). Comments on the new priorities are summarized in a separate report.
- Cross-cutting issues such as disparities, social determinants of health, the overall framework as presented in the slide set (vision, goals, principles, etc.) and other gaps and/or concerns.

Communities that Provided Feedback

Discussions were organized by diverse organizations across the state. In all, 50 groups varying in size from 5 to 25 presented information on the Prevention Agenda, solicited feedback, and summarized the discussion. Individuals also provided feedback. Groups and individuals had the option of submitting their comments in an online survey or via notes from the discussion. Some people submitted individual comments via survey. It is estimated that feedback was provided by over 750 individuals.

Findings

1. What did communities view as strengths in their experiences working with the 2008-2012 Prevention Agenda?

    - Overall encouragement by NYS to collaborate on community needs assessments and planning did foster collaboration between local health departments and hospitals.
    - Organizing the 10 priorities in the Prevention Agenda allowed groups to focus and prioritize along common themes.
    - Focusing on specific priorities enabled groups to leverage resources.
    - Collaboration and action was easier if the partners understood and believed in the benefits of the priorities, and if the group had access to content experts.
    - It was easy to work on broad priority areas such as access to care.
    - Communication on the Prevention Agenda seemed adequate, and was much more intense in the beginning.

2. What were some challenges working with the 2008-2012 Prevention Agenda?

    - Some organizations found it harder to collaborate. They alluded to the fact that possibly it was because they were smaller, had fewer resources, were on the geographic fringes of their more powerful partners, or the partners were not clear about their roles. Sometimes hospitals and local health departments did not collaborate, but when asked if it was important to do so, they agreed it was.
    - Not having access to content experts made it difficult to work on an issue.
    - Not having access to funding, though very few elaborated on specific funding needs.
    - Priority issues such as access to care and mental health were too broad, and it was difficult to identify actions that could be taken at the local level to make a difference.
    - Lack of access to zip code level data, and disparities data.

- Some groups did not see any positive or negative changes with respect to the Prevention Agenda

3. How can these strengths and challenges be addressed through the next version, the Prevention Agenda 2013-2017?

General Feedback and Recommendations

- Ensure the priorities and their implementation is connected with the "voice of the customer." Include "voice of community" at every stage and every level.
- Collaborate within and across sectors and continue to encourage collaboration between the various partners, especially local health departments and hospitals.
- Focus on Disparities and Social Determinants of Health
- Include data at sub-county level
- Include long-term indicators and intermediate measures

4. What should the specific priorities be in the 2013-2017 State Health Improvement Plan, the Prevention Agenda include?

Stakeholders were in agreement with the priorities. Some suggested a change in language of three of priorities, namely Chronic Diseases, Healthy Mothers/Healthy Babies/Health Children and Healthy Environment. There were questions whether some priorities should be listed individually or should be cross-cutting, and whether selected populations were included in the priorities. For details, see Pages 20-39.

Community Action

Feedback from the stakeholders provides guidance on the challenges and successes experienced by partners working on the 2008-2013 prevention agenda. The next steps are to consider the comments and the concerns in the context of the proposed priorities, clarify and modify as needed, and then develop action plans for each priority area.

Detailed Feedback

1. **Who provided feedback?**
   43 representatives summarized group discussions estimated to represent over 750 community members with groups varying in size from 5 to 25.

2. **Regions of the state represented (some groups may have checked off multiple regions)**

   Statewide – 17

   Capital –4

   Central – 9

   Metropolitan – 4

   Western - 8

17. Setting and or method used to obtain feedback (meeting, e-mail of survey to members, other).

In-person meetings: 33

Emails: 3

Webinar: 1

Conference: 1

Individual: 1

N/A 4

18. How many people participated in the feedback session?
Average Group Size: 11-25 based on eight responses (8?)

19. Stakeholders represented:

Health care, public health, community -based

Experience with Prevention Agenda 2008-12

Did your organization participate in the Prevention Agenda 2008-12? If yes, did your organization participate at state or local level?

Yes: 16 (7 at state level, 2 at local level)

No: 4

5. How effective was the NYS Department of Health in promoting the purpose and activities of the Prevention Agenda? Three said effective, 2 said neither effective nor ineffective, 2 said ineffective.

Specific Feedback on Communication and Coordination

Positive Aspects about communication at state and local levels	Challenges	Opportunities for Improvement
• The focus of the priorities helped focus the coalition. • Good communication, especially to public health people • As a grantee of Heal 9 we attended many trainings on the Prevention Agenda. • There was some but not enough promotion of the Prevention Agenda to stakeholders and community partners early in during the roll out. • The NYSDOH was very effective in communicating the purpose of the prevention agenda and met with us locally to discuss our progress. • We had to collaborate with other agencies and that was something we needed to focus more on all along. • The fact that there were several topics gave us the latitude to really address several issues and gaps in services in our county....especially access to quality health care. • County visit by Commissioner of Health and staff created media visibility on some of the agenda items. Visit from regional office also helpful. • I am new in this position, but it is clear that the basic bullet points of the Prevention Agenda are understood in the public health community. • PA has facilitated conversations about core competencies,	• It was difficult to know which priority to focus on as there were so many. It was then left to the localities to determine what priority they were working on; • The difficultly from a state perspective was letting our local medical societies know who was working on what. Communication not so (good) for physicians, communities or other constituencies. • If our statewide group was not a part of the Prevention Agenda Ad Hoc Committee and involved with the local Health Departments and local hospitals, we would not have known about the NYS Prevention Agenda. • It was difficult for us to participate at the local level. • Participation at local level was uneven. • Collaboration with hospitals was difficult. In addition, it was difficult for a small agency, such as ours to be able to find resources to help staff better understand how to implement evidence based strategies and how to evaluate those interventions. Also, it is very difficult to get "buy-in" from the governing authority when fiscally times are very tight. Our local governing authority wants the results now and	• It would have been helpful to include our partners, particularly hospitals, who did not seem to understand their role in the collaboration process. • More letters to the president or CEO of hospitals. Most presidents and CEO shuffled the progress reports off to outreach people or PR people and never paid attention to the concept and principles of the agenda at all. The rest of us (public health and rural health networks) were working diligently on the prevention agenda and collaborating, trying to engage hospitals and most hospitals paid lip service only. • Integrate messages across all public health program areas, such as preparedness and environmental. • More media presence both general and social. • Communication needs to be in a form that is translatable to all staff

complementary and synergistic programming, etc. (helped conversation around who does what? who does what <u>well</u>? and who <u>should</u> do what?) • Provided structure/framework for organizing information. • There did seem to be increased collaboration among community agencies as they entered into the planning and implementation process • Priorities can be used to focus efforts and be used in funding requests • Communication among partners was cited as very good. • In a few counties there were good examples of collaboration and action. • In Binghamton/Tioga counties, both hospitals and LHD at the table, product was good, positive experience. • Created shared accountability; common roadmap which is valuable • Engaged the hospital; previously the CSP by hospital was a marketing tool for hospital. • Requiring hospitals to partner with LHDs was a great strategy and has helped our county work more closely with the hospitals. • Although we had to address three prevention agenda items, our local focus was more upstream looking at broader systemic issues that impacted all of the prevention items. Therefore we used the prevention agenda items to help prioritize activities and for tactical implementation of our goals. - The Prevention Agenda provides coordination of resources for the	wants to see cost savings now, not five years from now, which we know take time. • Lack of hospital commitment at the highest level, especially since the local hospital was merely a part of a larger system that crossed several counties. • Competing demands or limitations on partners from funding sources made it difficult to adopt some of the evidence based programs that we would like to adopt. Data available from state data banks was of a nature or time frame such that outcomes of interventions cannot be readily measured. We also would need a longer time to carry out our interventions to see if they are effective. • Some LHDs where there was no in county hospital found that hospitals utilized by their residents did not consider out of county/area LHDs as partners within the hospitals' catchment area.	so everyone is on board. • More media attention • Provide local information to the state level about what county will be working on. • Communication should be enhanced from the DOH to other State Departments. • Integrate communication from the NY State Department of Health Divisions to its funded programs. • 2/3 of Rural Health Networks (RHNs) have been involved with planning and implementation of PA locally and in some areas, RHNs are the facilitating entity of the CHA and CSPs. They can help facilitate communication and coordination. • Hold local town hall meetings and bring information about the prevention priority agenda on site where people come for other kinds of assistance, get groups to post it on their facebook and other internet pages and ask for comment, do newsletter items for groups to use with their communities. • Better coordination with state and locality and ensuring that we

local health departments to address health issues and increase quality of care.		all know which • topics each county is embracing. • Should be organized on the order of community awareness projects and NYSDOH should include this in all communications and integrate into the funding requirements. • Talk to the Primary Medical Doctors, such as the Academy of Family Doctors, ACOG, AAP, NASW, MH Directors. They should be involved, they have a different perspective. • Dental, Office of Aging, CHCANYS • Behavioral Health, psychology, Mental Health Director's Association • We meet monthly with our hospital providers and are beginning our CHA process much sooner this year to allow for more time for joint planning.

Specific Feedback on Financial/Policy Supports:

Positive Aspects	Challenges	Opportunities for Improvement
• HEAL9 was used to address emergency room issues not covered by the Prevention Agenda. • PA provided common language which facilitated collaboration and fundraising • The work done with oral health brought funding in to support a van. • The current practice is highly engaging for us. Greater financial support, or consequences, and requiring collaborative solutions where the Department has the authority, will further engage partners. Additionally, broad engagement will increase when the Department is able to identify, quantify and leverage key areas where each constituency has financial skin in the game.	• The lack of financial support severely limited our ability to mobilize complimentary initiatives. • Funding was available to support some of the Prevention Agenda items. It is unfortunate that NYSDOH was not able to draw down more grant funding for LHD distribution. • Funding for local staff to promote/advance the agenda and NYS marketing. Marketing tools, particularly graphic images, for use by regions to grab attention on each priority area, would help local efforts to engage the public. • If they made some resources available to local communities, I believe the initiative would have been more effective. • Mental health/substance abuse challenging for LHDs because we were denied reimbursement under General Public Health Work funding for local partnership/collaborative work. It does not fit into state aid funding for LHDs.	• Need more funding for implementing interventions. • Make some funding available • While hospitals are offered incentives for making changes, local public health departments and communities are often not offered incentives for moving the needle on specific priority areas. I think that offering some type of funding would encourage people to be involved because they would recognize the sustainability of the project. • Funding needs to be increased and dedicated to support community awareness and social marketing for prevention initiatives.

Specific Feedback on Partnerships

Positive Aspects	Challenges	Opportunities for Improvement
• Good/mixed communication among partners • As a result of working on the prevention agenda, the county and the hospitals are a lot closer because of the process • Involvement of EMS to access and community preparedness, got public health more involved • Involved the FQHC, helped provide monthly program for Mothers, babies, and children as well as Mental health/substance abuse. Improved community preparedness. Brought organizations closer • Improved collaborations with county health as well with other agencies. • Because of the access to care piece, hospitals were more interested in working together on strategies since it directly addresses their goals.	• Leadership at the local level was lacking in some instances. • Behavioral health care providers were not involved in early discussions about the PA	• Continue to tie the local health departments' CHA and the hospital's CSPs together, and create incentives, and enforced requirements for those agencies to participate. • Jefferson County has good participation in planning processes. DOH could promote the importance of need regarding processes across various sectors, including traditional and non-traditional sectors. Increasing exposure of the process through media including social media and traditional media. • Conduct collaborative stakeholder meetings /conferences • Yes, Mental Health. Why the disconnect between the state agencies? • behavioral health providers need to be at the table

Specific Feedback on Data Capacity and Measures

Positive Aspects	Challenges	Opportunities for Improvement

	• The way data is being collected for BRFSS needs to change. (Collection of data by phone calls is limited by increased use of cell phones and less and less use of land lines).
	• difficult to measure success when access to data is not equal to everyone.
		• There were several measures related to occupational health in the current Prevention Agenda in the injury prevention priority area. Additional measures have been proposed. The occupational health group will be asked to review and comment on these measures. One such measure could be something that OSHA provides that identifies rates of injury above the expected rate by work site.
		• It would be great if data from other states to see how we compare, and see what we can learn from them.
		• Make community level data available statewide as it is on the neighborhood level in NYC. We could try to highlight were zip level data are available, such as PQI's
		  • Promote a two-tiered approach to selecting indicators:
		  • A common set of indicators across the state for each priority area so that county-to-county comparison is possible.
		• County defined indicators to allow localities the flexibility to understand prominent public health issues in greater detail and enable them to prioritize public health initiatives. (e.g., refugee health needs related to Prevention Agenda priority areas in two Central New

		York counties
		• Promote the use of leading and lagging indicators (both common and county-defined) for major topics within each priority area.
		  • Make data available for sub-county analysis (record-level or zip-code level).
		  • Sub-county data enables localities to best understand health disparities within a county by subpopulation, geography, gender, age, race/ethnicity, outcomes, etc.
		  • Record level data enables local health planning groups to define sub-county divisions(towns and neighborhoods) that make the most sense for local planning.
		  • Community resources are invested into targeted public health initiatives defined by specific local health needs.
		  • Examine the role of Medicaid and Managed Care data sets could play in this process to:
		  • Better define populations at risk (e.g., number of Medicaid clients with diabetes diagnosis by age).
		  • Use QARR data to develop population-based (vs. current

		plan-based measures) • outcomes/actionable indicators (e.g., management of diabetes, cholesterol levels, COPD, etc.). • Better understand the affect of poverty on health status and health outcomes. • Update indicators available on New York State Department of Health website to 2010 or better so that use rates can be calculated using 2010 US Census data. This is particularly important for the common set of selected indicators so counties can gauge their progress towards goals. • Incorporate the use of a global measure of health such as potential years of life lost. This measure could also be related to specific conditions (e.g., cardiovascular disease, diabetes or cancer). • Consider the use of data sources and indicators that bring cost into the equation. This will help the state to better understand the actual cost burden of disease and enables New York State to align with the principles of "Triple Aim" (improve the health of the population; enhance

		the patient experience of care including quality, access, and reliability; and reduce, or at least control, the per capita cost of care). • Increase sample size of Expanded Behavioral Risk Factor Surveillance System (BRFSS) and Pregnancy Risk Assessment Monitoring System (PRAMS) to improve county level data and provide data for major Upstate cities. • Consider the use of the following data sources: • Office of Mental Health planning data (e.g., the Patient Characteristic Survey, County Medicaid profiles for behavioral health clients, etc.), SPARCS, and Medicaid data to develop indicators for substance abuse, depression and mental illness. These data sets provide information regarding co-diagnosis and other useful information. • The online Hospital Profiles. The data could be used to develop population-based measures relating to the performance data. • AIDS Institute Reporting System (AIRS) data. The database could provide useful information regarding health

		behaviors and utilization of resources. • Update Prevention Quality Indicators (PQI) tool and improve user friendliness. The sample size is often too small at the zip code level to be useful for analysis. • Develop a zip code algorithm to facilitate mapping applications and population-based analysis. Such an algorithm would permit consistent and ready aggregation of zip code data by cartographic zip codes (those which have boundary files and corresponding (those which have boundary files and corresponding census-based population data).

Strategies

The Prevention Agenda had 10 priority areas: 1. Access to Quality Health Care, 2. Chronic Disease, 3. Community Preparedness, 4. Healthy Environment, 5. Healthy Mothers, Healthy Babies, Healthy Children, 6. Infectious Disease, 7. Mental Health and Substance Abuse, 8. Physical Activity and Nutrition, 9. Tobacco Use, and 10. Unintentional Injury. Did collaboration and/or progress go better for some priority areas? Which ones? Why?

Universal Appeal/ Few turf issues

- Access to Care has the universal appeal for providers and public health advocates as well as the infrastructure to build upon where there are no real turf issues.
- Access to health services has been a very important part of the existing Agenda
- "Access to quality health care" allowed us to form partnerships (e.g. facilitated enrollment, EMS, other)
- Community Preparedness had the support and mandate to mobilize action that was beneficial in enhancing communications beyond this one issue.

Clear benefits of working on issue

- The negative consequence of tobacco use is very clear and there are people responsible for working on this issue on an ongoing basis.
- It was easier to select a few areas to focus on although having all 10 areas allowed the community partners to focus on another area they might have felt was a priority to their organization
- All those items that related to chronic disease prevention seemed to be easier for all parties to understand and have some participation in.

Aligned with organizational priorities

- Tobacco. Because it coincided with one of our main priorities
- Access to Quality Health Care (because it made sense and could directly address barriers rural areas face: transportation; lack of specific services -- dental, children's health; lack of insurance; etc.) We started a dental center at the public health office --- something that could not be done before. Also Mothers' and Children's Health helped us offer outreach for this audience.

Infrastructure

- Availability of subject matter experts within public health staff was more robust in some areas than others. The top three Prevention Agenda items in Jefferson County that were focused on by hospitals and public health had more resources available.

10. Did some priorities seem to be more challenging to address? Why?

- Healthy Mothers-Healthy Babies-Healthy Children - the one we are most familiar with, we did not see any enhanced collaboration or progress from a statewide perspective.
- Access to local mental health data - many providers do not necessarily use EMRs that might fall under access for "meaningful use."
- Chronic disease issues have challenges routed in the strong influence of social determinants of health; but also data access, issues of the capacity of delivery systems to look beyond their patient services
- Availability of subject matter experts within public health staff were lacking in some areas than others.
- Access to care, for our location and size, was more challenging as we often felt powerless in improving access
- Access to Care was harder due to breadth.

- Infectious disease: Challenge to get increased HIV testing in ERs.
- It is difficult to capture people's attention about the dangers of physical inactivity and poor nutrition, unlike HIV or cancer.
- We don't really have the resources to affect access to quality health care and mental health and substance abuse. These are major problems in the county but beyond what we can do.
- Unintentional injury --- you need to include farm interests to address this in a rural area: Farm Bureau; Cornell Cooperative Extension; NYS Grange; etc. These are the agencies that directly deal with farming interests. Also, several rural farm accidents happen because of lack of knowledge and education (you need to reach out to the Amish and the Menonite communities who sometimes experience needless tragic accidents in the farming communities.
- We don't have much programming in mental health, substance abuse and injury prevention.
- Lack of resources to focus on Mental Health Silos and lack of adequate number of providers

15. How can we assure that our new plan addresses disparities in each of the priority areas?

DISPARITIES

- How much of the data is able to be cut and diced to be able to see the disparities? This re-emphasizes the importance of a planning group's role – a data repository of sorts where you can more adequately represent some of the under-served areas.
- Health plans need to collect race and ethnicity – they are not required to do so as of now and it needs to happen.
- Research needs to be conducted in order to know what disparities exist and how to use this evidence based research to successfully reach all concerned populations.
- Strong leadership is needed at the state level to change policy. If certain public policies are not changed nothing will be successful. To achieve this goal, X policy needs to be put in or revised, etc.
- The concept of "promising practices" is especially important in addressing diversity/underserved issues; most evidence-based studies use "majorities". Believe there's been little effective action in past because we haven't yet found the best practices for minority populations.
- Reflecting the diversity of the communities they serve, centers were pleased to note the attention to disparities in the draft material, and suggested an additional emphasis on provider education in addressing this important issue. A specific need for culturally sensitive staffing was raised regarding mental health services for homeless populations.
- Mandate that it be addressed.

Infrastructure – Coordination/Communication - Articulate access and utilization information

- By requiring articulation of access and utilization information for priority areas, disparities will be illuminated. This would be especially true if there were specific sub-populations for which access and utilization rates were requested.
- Community involvement is key. Understanding what the disparities are at first is key.
- What gets measured improves. Different regions need to receive or have access to data by race/ethnicity and other disparate groupings for local regions

Infrastructure – Partnerships/Sectors - Increase engagement with providers/workplace serving underserved populations

- Focus increased engagement/work with providers serving underserved populations (i.e., NYC HHC, FQHCs) Increased Medicaid strategies to allow for maximum impact of health care coverage (i.e., smoking prevalence reductions among Medicaid insured populations, specifically

address tobacco use in OMH settings - - which receive Medicaid reimbursement but do not address tobacco).

- Disparities are a concern in the breastfeeding community. Racial and economic disparities reduce the duration of mothers' ability to provide breast milk for their infants for the 6 months of exclusivity as recommended by the American Academy of Pediatrics and the US Surgeon General. We must advocate for employers to abide by the NYS DOL Nursing Mothers in the Workplace Law, as well as improving maternity leave for working mothers.

Infrastructure – Policy/Financial Supports - Broaden definition of disparities

- Sensitivity to the diversity regarding disparities including economic, racial, rural, urban, etc.

Infrastructure – Policy/Financial Supports - Provide incentives for people to focus on disparities

- Providing incentives for people to focus on disparities within each priority area is very important.

Infrastructure – Policy/Financial Supports - Address goals cohesively, not in silos

- The five goals need to be addressed cohesively and not in silos. Continue to keep abreast of current efforts at the federal level and incorporate the life course perspective in the Prevention Agenda.
- Tie it specifically to Article 6 state aid
-

Infrastructure – data capacity

- Need more zip code level data.

- Broaden the umbrella when talking about health disparities to include the impact of bias, culture, stress, and the environment

16. Would a member from your organization be willing to serve on a committee to address an identified priority?

More than 22 people volunteered. A few organizations said they would identify volunteers to serve in each of the workgroups.

20. Do you have any other comments that you would like to share?

- Partial service public health counties should be integrated in process.
- We should not be trying to shift directions every 4 years and lose momentum in programs that are just getting started. Fortunately our objectives from 2008-2012 fit very nicely with the proposed priority areas.
- We are very aware that to make progress on these items, it will require substantial engagement of more community members and persistent identification of both problems and strategies to address them. Greater promulgation of evidenced based strategies would help expedite that process, but to dent the consciousness of the public who is facing so many personal crises, there must be sustained resources to develop and execute effective campaigns. We would appreciate an outline, sample or some other model that would help hospitals and LDSS' fulfill their responsibilities.
- LHDS would like 1) Top down push for hospitals to work with partners 2) Sharing of LHD and hospital timeframes and guidance 3) Support idea of menu of actions that hospitals can take to meet their community benefit rules 4) Clear guidance on what type of activities are reimbursable under Art. Six State Aid for areas that don't traditionally fall under core funded activities (Mental Health/Depression/Substance Abuse) 5) Support for DOH to work with Mental Health/Substance Abuse state agencies to assist with access to data 6) Guidance/suggestions on how LHDs might work with Health Homes 7) Clear guidance on CHA and CHIP and MPHSP 8) Timelines so that LHDs/Communities can start planning for CHA/CHIP process 9) BRFSS data 10) Training for LHDs on QI as it relates to CHA/CHIP and accreditation Overall LHDs felt that State is moving in the right direction with priority areas and CHA/CHIP process.

General Comments on the Vision, Goals, Context, etc.

- Goals 2-5 are process items, not outcomes. Goals should be SMART - Specific, Measurable, Attainable, Realistic and Timely. Goal 1 could be the vision and 2-5 be operating principles.
- The 'goals' listed on slides 6 and 7 are really objectives. Only slide 5 should be labeled as a goal. - The 'health in all policies' principle should be applied to the current debate over hydrofracking –
- Health literacy is a very important principle and should be added to the slide on the Characteristics of a Public Health Approach –
- Can we collectively remain focused on one vision and not have to change that vision everytime leadship changes. At least the Healthy People is locked in for 10 year periods. ;)
- Is everything in the 2008 agenda included in the updated agenda?
- The " Public Health System" should be broadened to include other sectors (schools and faith-based institutions)

Proposed Priorities for Prevention Agenda 2012-2017

The proposed priority areas for 2012-2017 include:

1. Chronic Disease;
2. Healthy Environment;
3. Healthy Mothers, Babies and Children;
4. Substance Abuse and Mental Illness; and
5. Human Immunodeficiency Virus (HIV), Sexually Transmitted Infections (STIs) and Vaccine Preventable Diseases.

These five priority areas were described and stakeholders were asked if the new priority areas addressed health issues of concern for their communities and/or organizations.

10 out of 13 respondents (76.9%) answered "yes" to this question.

Stakeholders were also asked how their organizations might be most effective in addressing one or more of the priorities and if not, how they would change them or what different priorities would you suggest.

The following charts summarize responses received, represented by priority area.

Priority Area	General Comments	Strategies	Measures
Chronic Disease	• Chronic disease priority is good, but the idea that genetic pre-determinants can be totally prevented is ludicrous. Also, since there is a 75% increase teenagers today being Type 2 Diabetics, we are still left with the need for current treatment and not just prevention. This comment includes other genetically caused diseases for which prevention is not possible. (other than public health) to take the lead. • LHDs supportive of priority areas, particularly	• Get media involved, focus policy on increased taxes that influence behavior (beer, sweets, tobacco) increase physician reimbursement for preventable priorities(tobacco cessation). • Tobacco use program is a model program. Quit Line is accessible, low cost; the primary care doctor can fax the form right away, avoiding the need for patients to make their own contact. This program could be a model for the obesity program, benchmark in principles. • We serve a high risk	• Consider adding BMI to the measures as Patient Centered Medical Homes must track this • Note that we have a robust registry of high blood pressure in Monroe County, but it's hard to tell how many people actually HAVE a chronic illness. "Counting" will be a challenge in all measures. •

	integration of several earlier categories into one broader Chronic Disease category, which may help funding come in a more integrated fashion. • "Prevent" chronic disease – negative spin vs. promote healthy lifestyles. You need prevent and manage chronic disease because there is so much you can do to avoid getting worse. It is very healthy lifestyles focused. What about managing? What about preventing secondary issues coming from these chronic diseases? Maintaining health? Preventing exacerbation? Manage – local health departments COULD manage. • Can we change name of Prevent Chronic Disease to address those people who are already chronically ill. Wrong use of terms and suggest rewording: How do you "prevent" depression or mental illness? Same for "Prevent" Chronic diseases? How about address or manage? • Fully support focusing on these risk factors • Recognize it will take years to see the downstream effect on disease rates after reducing the incidence of risk factors • Focusing on the risk factors in an excellent approach • As we might expect, based on our successful	population for chronic disease and advance healthy environment priority areas. We'd like to be involved in getting messages out to our community about prevention of chronic disease and about strategies for improving health. We have web site, newsletter, activities, staff that could be deployed. • Self-management training programs to adults with chronic diseases. • Worksite wellness should be incorporated as a strategy in the PA (either in healthy environment or chronic disease prevention) Work sites should work toward making sure that work sites are accessible for people with disabilities. This could include creating sheltered workshops or making regular work sites accessible, in a way that does not discriminate against people with disabilities. • Perhaps "identify" for depression through depression screening. • Need to put effort into individual *behavioral modification.* We have to help PEOPLE make change. Use of self-empowerment theory, coaching, etc. will be important. Need to change the payment structure to support this. • There are great ethnic and racial disparities in chronic illness. Use risk factor assessments to identify	

	efforts to reduce diabetes by addressing underlying conditions, health centers would like to see an even greater emphasis on that preventable illness in the 2013 to 2017 plan. • Also, while I see the value in putting physical activity & nutrition under the umbrellas of Chronic Disease and Health Environment, I think you lose something when the public doesn't see identifying and addressing "PHYSICAL ACTIVITY & NUTRITION" in order to combat obesity as a choice when priorities are set o Several centers advocated for additional emphasis on cancer screening o Concern expressed about lumping tobacco into a general chronic disease priority. Will it get lost there? Need to explain the advantages of dealing with tobacco integrated with other chronic disease risk factors.	which populations are at greatest risk. • Identify what community resources exist in the high risk areas- Ex: Bronx "green carts" • Use of social service supports and faith-based communities may have more impact than medical interventions • The New York Statewide Breastfeeding Coalition, Inc. would be able to provide insight and recommendations to help promote, protect and support breastfeeding throughout New York State. Exclusive breastfeeding is known to help prevent childhood obesity, a major health concern in NYS and nationally. Through our networking, we are able to advocate for breastfeeding across many disciplines • Promoting risk-reducing strategies (tobacco cessation, healthy eating, physical activity) in the workplace	

Priority Area	General Comments	Strategies	Measures
Healthy Environment	• One of our coalitions and our county wide planning often address issues of built environment • Suggest change wording of priority to "Advance a Healthy and Safe Environment" in order to capture prevention of unintentional injuries. • Pay particular attention to children and their families • One respondent suggested that the recommendation to 'advance a healthy environment' be expanded to 'advance a healthy lifestyle and environment', in recognition of the need for active wellness programming by primary care providers. • Access to Care and Community Preparedness are important priorities and could be included in a Healthy Environment. • Occupational disease clinics focus on controlling exposure to disease. This entails learning about exposures at different worksites, sometimes it's hard to access the work site to learn about and control exposure.	• We serve a high risk population for chronic disease and advance healthy environment priority areas. We'd like to be involved in getting messages out to our community about prevention of chronic disease and about strategies for improving health. We have web site, newsletter, activities, staff that could be deployed. • Worksite wellness should be incorporated as a strategy in the PA (either in healthy environment or chronic disease prevention) Work sites should work toward making sure that work sites are accessible for people with disabilities. This could include creating sheltered workshops or making regular work sites accessible, in a way that does not discriminate against people with disabilities. • Need workplace, neighborhood, and faith community strategies • Need health community design and active transportation approaches • Need school-based violence prevention • Supported housing will be essential, as will safe parks, green space	• For Healthy environment: Include measures that assess hospitalization rates of Motor vehicle accidents related to pedestrians and cyclists Include a measure of food insecurity, such as use of food kitchens, use of food stamps at farmer's markets Consider Healthy Design - partnerships for sustainable environments. Federal Agencies like HUD are involved will we include federal agencies in planning? • Regarding measures, we need to be careful that they don't mix medical and social drivers; for example, people will land in the ED because they don't take their meds simply because they can't afford them • The same comment suggested a meaningful-use item to track exercise and diet counseling, as smoking cessation

		• This is MISSING Transportation Resources • Transportation still a major issue. They need to weave in factors that help us do our work, such as transportation. • Access to Care and Community Preparedness are important priorities and could be included in a Healthy Environment	counseling is now monitored.

Priority Area	General Comments	Strategies	Measures
Healthy Mothers, Babies and Children	• The Healthy Mothers, etc is pro-natalistic; focused on intendedness of pregnancy, please highlight contraception. • Is the only gender specific priority. Women who are not pregnant or parenting are left out of this equation. Need to title: Healthy Families, Healthy Women, Healthy Mothers, Babies and Children. • In the Healthy Women priority include (does not have to be in the title) include focus on older women services • Healthy Mothers, Babies, and Children: one of our coalitions is focused on early childhood obesity and the preventive measures for mother and child that go along with this issue. • Oral Health should be included and emphasized • Agree that Oral Health should be a priority as it relates to many chronic diseases; specifically obesity. No reimbursement for prevention for primary care	• The New York Statewide Breastfeeding Coalition, Inc. would be able to provide insight and recommendations to help promote, protect and support breastfeeding throughout New York State. Exclusive breastfeeding is known to help prevent childhood obesity, a major health concern in NYS and nationally. Through our networking, we are able to advocate for breastfeeding across many disciplines • Liability reform to address malpractice rates should be strategy under Healthy Mothers, Babies, Children • FLHSA does not have access to state data on maternal child health and of % of planned pregnancy; need to address data access to engage and promote accountability for change • The Nurse Family Partnership is an excellent, EBP that should become a standard across the state • Focus attention on pregnant moms; coaching, behavioral mod	• Look at the metrics currently used in Managed Care to make sure they align

		• The MCHBG has specific goal areas that could be included in the SHIP plan for Healthy Mothers, Babies and Children, along with HP measures they are tracking that could be used. • Assuming no gaps in funding and congruence with work requirements, all of our members are committed in incorporating these activities in our work activities. As the Association of Perinatal Networks, we will continue to educate our policymakers and legislators at the State level and will communicate with other statewide organizations. We can also ensure the other perinatal networks are aware of recent updates of the Prevention Agenda. • Promoting infant health and development is amongst the most preventative tasks that society can undertake and as with any difficulty, disorder or disease it's naturally best to intervene early for best results. I would like to see the Model developed by this Committee feature infant health and development including maternal/child health more prominently. As the PHHPC and this Committee is a development of the NYS DOH, I would like to see the NYS EIP be featured more prominently in the	

		overall plan. Early Intervention Providers are a safety net to children and families under stress. Most EI services are delivered in the home, therefore, in addition to providing rehabilitation, educational and training services, EI providers are the eyes and ears for children that cannot speak or defend for themselves. As mandated reporters for suspected child abuse and neglect they are also in a position to protect children and be a vehicle to ensuring that fragile families have better support. I look forward to your response as to how I can participate in the work of the Ad Hoc Committee of the PHHPC. • For oral health, will need to be clear about why fluoride is a good public health intervention as some communities are concerned about toxicity of fluoride. Also need to address that fact that dentists don't accept MA	

Priority Area	General Comments	Strategies	Measures
Prevent Substance Abuse, Depression and other Mental Illness	• Consider calling this Promote Behavioral Health and include mental health, substance abuse and co-occurring disorders. • Mental Illness needs to be restated to be promotion of mental health...there are mental health needs that are not just mental illness. • With the "Prevent" for Substance abuse, Depression and other mental illness, it will fit with the work we've been doing with physicians regarding the prescribing of narcotics as well as looking at the number of liquor stores in our community. • Wrong use of terms and suggest rewording: How do you "prevent" depression or mental illness? How about address or manage? Perhaps "identify" for depression through depression screening. • There is a HUGE problem with access for mental health services for children • Behavioral health concerns were raised as a priority issue in their own right and as an issue that also affects physical health outcomes. In this area, mental health services for children and adolescents were identified as a salient consideration, as was the difficulty of recruiting mental health staff in various areas of the state. • We had general	• On drug abuse: focus on prescription drug and synthetic narcotics • We are assisting the creation of health homes in WNY • Emphasize role of community health workers Include clinical social workers when planning Mental health, substance abuse, depression priority area. • Must include mental health providers-Include Community Service Boards, LGU (something behavioral health I think)? School Health Planning processes, etc. • Recommendation to find ways to include mental health/hygiene, DSS, and those providers with wrap around services, i.e. homeless-must have someone stably housed before other health issues can be addressed • The reimbursement for mental health services in rural hospitals is low and this needs to be changed • If you don't have the capacity and proper screening for depression, it should not be done. • Suicide/depression screenings are not done by the majority of the medical community • Need to ensure that alcohol use/substance abuse priority area collaborates with primary care: OASAS focuses on youth and alcohol use prevention among youth but puts less effort into screening and access to services. More needs to be done with collaboration between	• The decrease we have seen in drug-related hospitalizations may simply be because of coverage, or lack thereof, not because of a real decrease in the use of drugs

	agreement that Mental Illness cannot be prevented, but must be addressed as an important component of other health needs.	substance abuse and primary care providers. Also alcohol is mentioned in chronic disease priorities and not other substances possibly because there is more data/research in the area, and alcohol is among the most common of abused substances. • The strategies need more exploration. The Commonwealth Report of Counties shows huge opportunities to find new ideas • Need to include PTSD, Domestic Violence, Anger and Conflict Management, Adverse Childhood Experiences • The example strategies are not very compelling; specifically, reducing alcohol access to youth is a losing strategy. Recognize that it takes a lot of work to screen for depression and make appropriate referrals in primary care and other health settings; may not be realistic without a change in the compensation/incentive structure • There's a lot of money already invested in decreasing the use of alcohol and drugs; are we saturated, and is it effective? • Some areas have shortage of mental health providers but people with a need for short-term assistance in that area. That should be taken into account.	

Priority Area	General Comments	Strategies	Measures
Prevent HIV, STIs and other Vaccine Preventable Diseases	• HIV, STI, and vaccine preventable diseases probably needs to be restated as infectious disease and vaccine preventable diseases • This is VERY specific. • Excellent focus, excellent action items	• We made great progress in NY in reducing the number of babies born with HIV. What can we learn from that experience that we can apply to other efforts? • We run an STD clinic so could probably most effectively address #5 and do greater education in this area. • Some counties are leery of talking about HIV and STI or even acknowledging these are issues in their county • Crack down on physicians required to use NYSIIS. That would enable the plans to be more effective on immunizations.	•

Priority Area	General Comments	Strategies	Measures
General Comments	• New areas are action oriented versus topical. What explains the shift which appears to create gaps? It appears to neglect entire populations. • Mobilizing the community to develop joint strategies and finding key stakeholders • Regional Health Planning organizations are well positioned to coordinate and staff regional, and highly localized, initiatives to address identified health needs. This is a natural continuation of our historic and current role of convener, data analyst, best practice researcher, and initiative	o Advocacy at state/local level should be considered as one of the strategies o Leadership is key in making this happen – including social determinants and preventive health within o Is the Vision realistic? By 2017 we are the healthiest state? Would feel better about NY will be the top 10. Concerned that we do all the work and then there is no money in place to continue on that path. o It's hard to differentiate	o I appreciate the reduction of measures; however, you are picking measures that are very difficult to see change within five years. Are there specific measures that are easier to measure / define of progression versus a huge number like obesity rates?

	developer. The breadth of our impact fulfilling these roles depends on having sufficient incentives and fiscal support so that all public health sectors can become more aligned around best practices to improve health outcomes, reduce costs and improve the patient experience. This work occurs through engaging community partners, identifying service gaps, and developing wellness strategies that combine policy changes impacting health, prevention strategies, culturally responsive service initiatives, and improved care transitions. • Strengthening engagement at the local level where possible, considering limited staffing/resources • Obtaining funding to implement policy and environmental changes in all priority areas. o Need to include unions (and their benefit funds) in the list of groups that play a role in improving health, in addition to employers. o Need grass roots consumers on the work groups going forward. Why not some peer educators, for example? o As part of the development of the State's Health Improvement Plan, the DOH should solicit input from the LGBT Community and ensure that LGBT health disparities issues are taking into consideration during the plan development. o The DOH should reach out to State Ed. regarding the Dignity for All Act and explore possible avenues of collaboration. A link to information about the Act is here: http://www.nyclu.org/issues/lgbt-rights/dignityall-students-act	goals 3 and 4. o These goals seem more achievable because avenues for payment are changing and for the better. Didn't expect these goals under this vision o What about the non-governmental infrastructure capacity? o The infrastructure capacity needs to be bolstered as well. Concern that these will be forgotten when the rubber hits the road. DOH needs to change the way that they fund to help out communities that have already been doing the work. Funding should be tied to indicators as well. o What are "promising practices" and "next practices" – use other terminology or define better. No one knows what a "next practice" is. Should innovation be in there? Who decides what is a promising practice? This pushes publication in order to be best practices and is that where we want to spend time and resources? o What does it mean that Health departments have leverage to make change? Are they saying that local health departments can do what they want? Is it influence? Or funding? o Health departments have a fairly limited scope and it will inform the work done by them. o Conduct an inventory of related efforts across the state and find ways to cohere each of them to achieve results	• There needs to be interim measures to understand if you are making progress. • Members also highlighted the need for assistance with developing process measures and how to develop indicators for their priorities going forward. o Task Force members also commented that it would be helpful if DOH would lay the groundwork for looking at the county health assessment indicators and attaching some measurements to the indicators

	o Perhaps inclusion of the PA <u>does</u> need to be mandated for some agencies/organizations- "Force" partnerships through applications and plan requirements. o Suggest incentivize ongoing collaboration even after the CHA's/CSP's are complete o Suggest getting Primary Care Providers and County Medical Societies involved; discussed the inherent limitations that DOH cannot mandate private entities to participate – o For non state funded/regulated entities: suggest "recommending" inclusion/consideration to integrate PA in planning and programming o Engage other helping organizations who may not be directly involved in public health initiatives/practice such as Community Action Agencies, etc. who are required to develop plans- encourage/advocate for alignment with PA o Allow for local determination of priority areas o DA's and Veteran's Courts, VA, FQHC's o Have to get the hospitals on board with the overall plan o The Voice of the Customer is an essential principle. We must talk to consumers throughout the process, including in the development of specific actions. The consumer needs to feel that the plan is FOR them and will work for them o The FLHSA has established effective models to bring customers and other constituents into the conversation, and that approach can and should be replicated across the state. ▪ I like the action words, but we are not sure if they are the	against these priorities. Examples of "related efforts" include: ▪ 1 million hearts campaign ▪ Projects funded by the NY Health Foundation and the Greater Rochester Health Foundation o Need to make investments in developing sustained conversations and trust. Until we have open community trust and support we can't develop an accountability structure that supports change for the long-term. o Health data literacy on all levels. • Is there a way for the average citizen to feel a part of the statewide initiative May to make New York the Healthiest State? Interesting idea. Worth considering branding the effort and trying to do some media/press releases/materials on this. However, it is not integral to the initiative, at least the way we have thought of it, and probably not too interesting to the general population. • Align timeframes for plan submission across increasing numbers of agencies • Make sure that the priorities <u>cover the lifecycle</u>	

	correct action words • Consider making approval of county-specific plans contingent on demonstration of an excellent process for including consumer input. • Can we make the basis for any county plan be a "community plan", ie, must be a collaborative across the components of the "Public Health System" • State should provide more direction/options/specifics on how managed care plans could/should participate at local level in collaboration. • Before the release of an RFP with mandates for partnerships, NYS should look at areas natural partnerships. Ex. Rochester was asked to work with an agency instead of the WNY coalition with whom a strong partnership is already formed. • Some hospitals came to the table only because they were required. • FQHC's should be at the table and a part of the planning. They serve others that hospitals and PCPs don't. • Unfortunately one agency is working against better access to care – DSS. With delays in applications and failed improvements to the process, a local commissioner has even said he doesn't want people to apply. It affects people seeking preventative services and deters those from providing care if unsure the person is covered. DSS should be a great collaborative partner. • Could state provide an opportunity to include private industry and business. Industry has an interest in improving an unhealthy	• Continue use of "health equity" and social determinants of health in definition • Access-treatment <u>is</u> prevention in behavioral health • It would be great is NYSARH focused on one or two of the priorities and focused on a state-wide application and distributes the dollars. This was agreed with by several members. • Data Collection – difficult to measure success when access to data is not equal to everyone. • Social determinants of care: We focus on them, but funding gets so targeted it doesn't allow you to address those social factors. • Participants recommended that the Health Improvement should focus on social determinants • In the process of addressing "health in all policies" there must be concerted efforts to ensure that new policies do not further widen health gaps • Develop culturally tailored educational and guidance materials for the public • Expand outreach to other relevant stakeholders (older adults and their caregivers, members from the media, Department of Corrections, Commercial vendors) • Explore areas outside of the healthcare domain that influence health	

	workforce. • The " Public Health System" should be broadened to include other sectors (schools and faith-based institutions) • Not much familiarity or working knowledge within the group. • Catholic Health chose diabetes as a priority. Not sure what they did with that information. • Do not resonate with it. Have not seen a progress report. It would be helpful to know what we need to worry about / have we made progress etc. • Has anyone has ever used it? We don't. It was an activity for the state. Hospital and LHD have worked well together in the rural areas. • Have not been invited back to meetings with hospitals or LHU to discuss activities or progress • Have no money to implement these priorities. • No one came back to discuss what the outcomes are. • Was there a state health report discussing how we did with this agenda? • These priority areas are mostly in direct alignment with HP 2020 to support grants etc. But, it does not inform any other aspects. It is not linked with other projects. • Do all of these fold into the ones that we are discussing for the coming year? • I think they've done a better job this go around with a prevention agenda vs. a health agenda. • The people who utilize the system should be included such as WIC recipients. • Caregivers need to be included too. • Some of these priorities are going to impact payment.	outcomes • Broaden the umbrella when talking about health disparities to include the impact of bias, culture, stress, and the environment • Create taskforces or working groups to tackle specific social determinants • Conduct activities such as summits and conferences to educate the public • Identify existing assets and needed resources • Develop inter-generational programs • For each priority area, consider focusing on ONE significant action item across the state. May be able to move the needle if there is broad support for a single effort rather then distributed support for multiple actions. • Focus on kids and families will bring greatest rewards; change their behavior NOW for future health improvements and generational change. • County Health Departments have been the lynchpin of SHIP over the years, but their funding has been cut and many of the programs have been gutted. How do we accomplish change differently? • CHHAs have historically provided a lot of public health; concerned about the unintended	

	Include managed care plans-Medicaid. • Are we just making it bigger and bigger and bigger? We know that every single organization needs to be a part of it in order to help change the public health. • What about Headstart? • One of the things on the agenda needs to focus on natural planning capacities. How do you encourage support for each of these groups. Organization involved should be each region's planning group that would drive this forward. The State shouldn't mandate who plays together though. It should be natural relationships that are already in existence. • Again reflecting the specific vantage point of FQHCs, comments on a patient-centered approach specifically noted issues of literacy and the implication of that problem in targeting prevention efforts • Voluntary agencies should be included in the development and implementation of the new state prevention agenda • Concern was raised about who will do the work related to this agenda and how will it translate into action? Hospitals are already overwhelmed with meeting their specific agency missions and we need a way to incentivize hospitals and other agencies in the communities to participate in this collaborative effort. • Make sure we link these proposals with what is occurring in MRT and Health Exchange • When the state releases funding, it needs to be distributed in an equitable way rather than going to just	consequences of the new managed care environment • The Brooklyn project has been an excellent cross-cutting effort; can we duplicate that process? • Recognize that each priority area impacts the other • MSSNY already has specific committees that focus on each of these priorities which will help greatly along with the knowledge that these are the Prevention Priorities. • Make sure the committee addressing the area has an understanding of the disparity issue and has action plan for disparities	

	higher populated, urban areas. Look at percentage of need and not just population. • Is reimbursement a problem? • Access to transportation - We could have the most elaborate healthcare system around, but we still have barriers to access. Medicaid assists with transportation can be limiting. This demonstrates a need for wrap-around services. • Re-allocation of funds that were going to Lead or HIV – are they going to other PH initiatives? • Is there research that shows that income actually improves someone's health? • Discussion that income is a part of it, but is also impacted by a variety of factors • gun violence could go under several priority areas • Community Preparedness/ and EMS should be reflected in these priorities. • A narrower, shorter list of priorities will mean fewer resources for certain initiatives; funding will follow the priorities • If priorities change-may lose some enthusiasm/momentum to continue. Agencies will not want to stop work on an initiative "mid-stream" • An often repeated concern is that people/agencies will narrow their scope under new PA which seems very limiting as opposed to open. It will be tough to add items to the list once it is "set in stone" • Question: How and when we will be introduced and trained on new priorities? • What about unintentional injury? • What about access to care? • Is everything in the 2008 agenda included in the updated agenda? • difficulty in choosing priorities		

	for the Prevention Agenda and going forward because many hospitals have developed programs in all the priority areas.		

Proposed Priority Areas

Suggested Priority Area	Comments	Strategies
Access to Care	o We think that access to care issues must be articulated for every priority area. Diagnosis and treatment capacity, education initiatives, self-management support services, insurance coverage and cultural relevance are all key access issues. o There should be a priority area on access to services. o Need to make sure issues related to access to care/disparities are worked in to each of the priority areas, and/or strategies. Addressing access to care issues draws in partners from the care community. o Keep Access to Quality Health Care as a priority by itself. Also there is need to address health care resources (education and recruitment of new nurses and providers). There is nothing explicit in the proposed agenda for training and pipeline issues for health care providers, nurses, and other professionals and para-professions, including EMS resources. o Access to Care should be added as a separate category: Access to health care services means health services, not access to insurance. Access to health services includes education and prevention, and is the way to document and involve consumers/community in the Prevention Agenda. o Access should also include the growing number of providers who are refusing to take Medicare; so coverage might exist but difficulty finding a	• Access to Care may be inherent in each of the 5 areas, but wishes it was more obvious. It would include transportation, access to doctors, urgent care, etc. Access to care also helps with preventative programs. • Community Health Task Force (a workgroup coordinated by HANYS) members indicated that access to care is still missing from the priorities, but could cut across the five priorities that have been established. • Homelessness and lack of housing were mentioned as large barriers to access to care. Task Force members indicated that it was critical for social services departments to be at the table during community health improvement discussions.

	provider who will accept Medicare. o Access to quality health care has fallen off the grid; it was helpful to see reference to this in the past. o View health priority areas through the lens of MRT-how do they relate and inform each other? What is the interface, if any, between the PA priorities and the MRT, health home, etc.? How will the concepts be operationalized through concurrent initiatives? • I need to re-emphasize the need for and importance of explicitly including access to quality health care. In health care there is a famous legal saying: "If it wasn't documented, it did not happen." The same applies to the prevention agenda, if access to quality health care is not emphasized; it is not going to occur. I also need to include this comment: prevention is a very good idea (the turn of the 20th century pioneers in American medicine understood that prevention was extremely important. It is sad it has taken us more than 100 years to try to effect change to address true prevention). However, at the same time, current treatment for affected populations needs to occur in the present as well. The first impression of the proposed prevention agenda is that it is so future oriented it neglects the need for current treatment priorities. o Access to care is no longer one of the priority areas. Need to explain why. Is it assumed in some of the priorities such as chronic disease? – Concern expressed about lumping tobacco into a general chronic disease priority. Will it get lost there? Need to explain the advantages of dealing with tobacco integrated with other chronic disease risk factors. o By reinserting the Access to	

	Quality Health Care agenda item. It allows flexibility. What you fail to realize is that in conservative upstate, Republican Counties (and in myopic. large health care systems), if something is not explicit the assumption is that it is not necessary to address at all. Thus, the idea that access to quality care is somehow understood and is a framework assumption is much too subtle for the two previously cited groups.	

General Gaps and Concerns
• Where does public health emergency preparedness fit in? • Where do these 3 issues fit into the new PA? o Dementia $2.2 billion cost annually-not adequate funding to take care of this population o Autism-high prevalence-no services o TBI (Traumatic Brain Injury)-returning veterans are “lost” in the community. Service providers are not clear about diagnosis, so veterans don’t fit neatly into chronic disease category; no real services available • Where do some critical issues fall? Missing or seemingly under represented: o Oral health, geriatrics, tobacco use, insurance coverage o Access to health care, health equity, health disparity-get them back on! o Workforce: recruitment and retention-get this back on! o Safe and affordable housing/homelessness o EMS o Quality: air/water/hydrofracking o Recruitment and retention of providers to rural communities