

Moderator: Hello, and welcome to Public Health Live, the third Thursday breakfast broadcast. I'm Rachael Breidster, and I will be your moderator for today. Before we get started I would like to ask that you please fill out your online evaluation at the end of today's webcast. Continuing education credits are available after you take our short post-test and your feedback is helpful in planning future programs. We encourage you to let us know what topics are of interest to you and how to best meet your needs. Today's program is *Prevention Agenda 2013: A Blueprint for Community Action to Improve Health in New York State*. Our guests are Dr. Jo Ivey Boufford, the President of the New York Academy of Medicine, and Sylvia Pirani, the Director of the Office of Public Health Practice at the New York State Department of Health. Thank you both so much for being here.

Dr. Boufford and Sylvia: Thank You.

Moderator: Now the Prevention Agenda 2013-2017 is New York's plan to improve the health of all New Yorkers. Over the last few years, New York has been in the middle of the pack in national rankings of population health status. New York State ranks 18 in America's health rankings, but New Yorkers should have good health and as good a quality of life as those in the top ranked states. You, New York's public health leadership, are the key to implementing a prevention strategy. Before we hear from our speakers today, we're going to take this opportunity to watch a short video discussing prevention. Let's take a look.

[Video]: The New York Academy of Medicine was established in 1847 by a group of physicians who were concerned about the quality of care in New York and since then we've been very involved in a whole series of important public health issues in the city. Our current priorities are healthy aging, prevention, and eliminating health disparities. Prevention is, we believe, the key to improving health of the population. It's wonderful to provide access to care and treatment to people when they're sick, but it's also important to try to avert disease whenever possible to prevent suffering and to prevent health care expenditures that could be devoted to other investments. There are two important ways of intervening on prevention. One of them is personal prevention. The second very important area, and the evidence is increasing about how important this is, is community-based prevention. There's been very good evidence that preventive activity makes a difference and increasing evidence especially in areas of tobacco, exercise, diet, and alcohol, that we can actually make interventions to create healthier communities who make the healthy choice the easy choice for everyone. Prevention has really become a critical part of improving health care, and in New York State, Governor Cuomo and Commissioner Shaw have been at the leading edge of efforts to capture savings for health and the health care system through prevention. Let's take a moment to hear from Dr. Shaw.

[Video-Dr. Shaw]: Why is it important for New York State to have a Prevention Agenda?

[Video-Dr. Shaw]: Well, we need to work together to focus our priorities to make any progress. Five years ago, we had a prevention agenda that focused on ten areas. This time we're working on focusing on five areas, and really making progress in short terms on measurable evidence-based programs and policies that will help improve the health of all New Yorkers. Our Prevention Agenda focuses on five areas. These five areas focus on the Promotion of Healthy and Safe Environments, the Prevention of Chronic Diseases, the Promotion of Healthy Women, Infants and Children, the Promotion of Mental Health and Prevention of Substance Abuse, and the Prevention of HIV, STDs, Vaccine-Preventable Diseases and Healthcare-Associated Infections.

[Video-Dr. Shaw]: What's new about the Prevention Agenda of 2013-2017?

[Video-Dr. Shaw]: Well, this time we were able to work with over 140 different groups from across all of the communities of New York, including local public health hospitals and primary care systems, to come together on what our agenda should be. The five areas that we selected were, at the end of the day, something that we all selected together. That's where the evidence is greatest, where we are best able to measure things over time, and where we can make an impact over time.

[Video-Dr. Shaw]: Why is collaboration so important?

[Video-Dr. Shaw]: You know, in the old days, it was all about creating niches and competing. Today we know that success only comes from sharing and collaborating. Just look at Facebook and open government initiatives. For us, we decided that the Prevention Agenda has to embrace these principles. It will only serve as a guide to local health departments and it will mobilize the community partners to assess health status, identify local priorities, and develop and implement interventions to address these priorities if we can get collaboration working across the spectrum. Hospitals and local health departments are doing this in conjunction with required community health assessments, community health improvement plans, and community service plans. In these tough economic times, one may ask, how can we take on these added roles and responsibilities? The answer is we can't afford *not* to take on these roles and responsibilities. By focusing on a smaller set of priorities, we can actually move the needle much further than each of us working independently on our own separate programs that collectively don't make an impact.

[Video-Dr. Shaw]: What is my vision for New York State?

[Video-Dr. Shaw]: Under Governor Cuomo's leadership, we've made significant strides in improving the delivery of healthcare services through our Medicaid program and improving access by building a health benefit exchange. But we know that the health care delivery system is only responsible for up to 20% of health. The social determinants of health, our behaviors, and the environment influence a vast amount greater than the 20% of the health care delivery system. Our hope with the State Health Improvement Plan is to focus on the behaviors and the environment, and improve those over time to impact health in a much greater degree than just the health care delivery system. Thank you.

Moderator: So it was really great to see both of those videos and I think it really helps to set the context for what we're talking about. It's clear from both of the videos that New York State is really working towards a prevention orientation. Now Sylvia, Dr. Shaw mentioned the importance of working collaboratively, and working where the evidence base is greatest so we can make the most amount of progress and measurable progress over time. Can you tell us about some of the urgent health issues and disparities that are driving the Prevention Agenda?

Sylvia: Certainly, Rachel. Let's look at some of the data that illustrate what issues are most important and where the greatest disparities exist. On this slide, you can see some of the most severe outcomes. This graph shows the number of deaths for some of the leading causes of death per 100,000 New Yorkers over the last ten years. Heart disease, cancer, chronic lower respiratory disease (CLRD), and stroke are all chronic conditions that are largely preventable and are addressed by one of our priorities:

Prevent Chronic Diseases. Pneumonia and Influenza are vaccine-preventable infectious diseases and fall under the fifth priority group: Prevention of HIV, STDs, Vaccine-Preventable Diseases and Healthcare-Associated Infections. Unintentional injuries round out the group and are often behaviorally modifiable and fall under two different priorities: Promotion of a Healthy and Safe Environment, and the Promotion of Mental Health and Prevention of Substance Abuse.

Moderator: So when we look at that big picture and those leading causes of death, how many of them would you say are preventable if we were able to modify behaviors?

Sylvia: A national study published in the March 2004 Journal of the American Medical Association found that 46% of actual causes of death are attributable to eight modifiable behaviors. This slide shows the estimated number of deaths in New York State due to modifiable behaviors. Tobacco, diet, physical activity, and alcohol contribute the most to the estimated number of deaths, and each of those eight modifiable behaviors that you see in the slide link to one or more of the five priorities of the new Prevention Agenda.

Moderator: Now in looking at that chart, tobacco is really leading the pack there, if you will.

Sylvia: Yes it is.

Moderator: Can you talk to us a little bit about tobacco use in New York State?

Sylvia: Certainly. You're going to see in the next slide the age adjusted percentage of smokers in New York State. The darker the color on the map, the higher the rate. The overall current smoking rate for the state in 2009 was 17%, but what you see on the map is that some geographic disparities exist. The county rates varied from the lowest rate of 9.7% among Rockland County residents in the Hudson Valley to the highest rate of almost 31% in Chemung County residents in the Southern Tier. In general, our upstate counties had higher rates of current smokers.

Moderator: Now, when we look at these different health conditions, whether it's tobacco use or otherwise, is it true that they don't affect all New Yorkers at the same rate or they don't affect all New Yorkers equally?

Sylvia: Correct. We have a lot of disparities in health conditions in New York State. We have unacceptable disparities, for example, for people who have health disabilities and the next slide will show you the disparities for that group compared to those people who don't have health disabilities. The blue bars are the indicators for the rates of disease for cigarette smoking or obesity for those with disabilities, and the red bars are the rates for those without disabilities. So you see in some cases almost double the rate of these diseases in people with disabilities.

Moderator: Which is a pretty staggering disparity to look at the chart like that. Now, there are other conditions as well that disproportionately affect certain groups. Can you talk about some of those?

Sylvia: Sure. We have many disparities in different diseases in New York, unfortunately. Health disparities exist for different outcomes such as premature death before the age of 75 for the American

Indian group versus the White Non-Hispanics, and high breast cancer incidence for Whites versus others. What you see on this slide is the heart disease death rate. Even though the rates have been declining over the past decade for all racial ethnic groups, the disparity still exists. In 2009, the heart disease rate was almost two and a half times higher among the Black/Non-Hispanic group, which is the top of the graph there in pink, compared to the Asian/Non-Hispanic group at the bottom of the slide in the dark red color.

Moderator: Clearly some big pictures to look at with the different disparities you talked about.

Sylvia: Absolutely.

Moderator: Now Jo, in addition to looking at health status and health disparities, what else went into consideration when you were developing the new Prevention Agenda?

Dr. Boufford: We really wanted to start by looking at what worked and what didn't work the last time between 2008 and 2012, and at that time as the Commissioner said, the plan included ten priorities. We decided to narrow in on five priority areas for this part of the plan to get more concerted action to see the results at the community level. Collaboration was an important theme for the first Prevention Agenda. But in fact, the plan was largely developed by the State Health Department and we did bring in a group of organizations and individuals statewide to help with implementation. We knew we needed to start this process earlier this time around. As we looked at the outcomes reported at the local level of the planning process, it was clear that many local communities, the hospital directors, and the public health department directors did work together. But with others, it was more difficult. In many as well, they were not able to bring a lot of other community institutions or individuals to the table, so that had to be a focus of concern. Part of the reason was they needed more support; more technical assistance on the partnership issue, on setting priorities, and on developing implementation plans and evaluation. So again, we paid a lot of attention to that in this new plan.

Moderator: So how was the development of the plan different this time around?

Dr. Boufford: Well, we started with the plan really being led from the very beginning by an ad hoc committee of individuals and organizations statewide. They were officially appointed by the Public Health and Health Planning Council. They had this status working in partnership with the public health committee members, including key leaders around the state, in the hospital industry, in public health and professional associations, state networks of advocacy groups concerned about various health issues, professional associations, and the business community. This group met four times during the course of about 18 months to really help shape the initiative from the beginning. They reviewed and approved the final draft of the report before it went to the state Public Health and Health Planning Council in December.

Moderator: It seems like you certainly got a lot of people involved in the process. Can you tell us why it is so important to have such a large group of people helping to form the new plan?

Dr. Boufford: Well, broad participation is really important because in creating the plan we really wanted to tackle the many determinants of health beyond the personal health care system. So this diagram that's going up is from a very important paper by Dahlgren Whitehead. What it says here is that if you look in the circle in the middle, we're really born with some kinds of attributes that can't be changed: age, genetic make-up, sex, and race and ethnicity. As soon as the child is born, these influences from their families and from their communities begin to have a strong influence on their health status. When we move out into the community, we begin to see that wider influences on health that shape resources available in communities like housing, workplace conditions, crime and public safety, the availability of healthy food, and places to exercise are all really shaped by health policy. The weight of the evidence is getting to be pretty convincing that we've got to act on these factors if we're going to see results in the community's health.

Moderator: Isn't the health Prevention Agenda really a government initiative, though?

Dr. Boufford: No, not really. Some people think, and I think we've seen here in New York, that while the governmental public health agencies are sort of the backbone of the public health system, the concept now is that the public health system really has to include multiple stakeholders. The next diagram you can see the model that's really been built by the U.S. Institute of Medicine. It really states that you've got to try to identify for any particular health issue where the resources are in a given community to develop a plan and to begin to implement the plan. So again, you see the same list of stakeholders: business, academia, committee-based organizations, and the health care delivery system, which in New York is a major factor. The challenge of developing the Prevention Agenda will be really aligning the interests of all these potential actors at the community level to really get the highest health results for individuals and for that community.

Moderator: I have to say, listening to everything you've just shared, the scope of this sounds very ambitious.

Dr. Boufford: It is ambitious, and I think happily we were able to really take advantage of what we've learned since the last time the Prevention Agenda came through. We've really been using a model that requires each of the teams and groups that are looking at the big five goals for New York State to really look at a wide range of interventions. So we've been using this pyramid structure, which was developed out of the Centers for Disease Control as a framework for action at the five levels of public health systems. One is, if you start at the top, we see the engagement with personal counseling and preventive services, which are emphasized certainly in the new health care reform at the national level, such as immunization. As we begin to move further down the pyramid, we see that we bring individuals into looking at the circumstances they live in in their communities and how can we change environments, clean water, safe roads, and availability of healthy foods so the healthy choice is the easy choice for them? As we move even further down, we really confront this sort of outer circle, if you will, of the last diagram where the policies that create the conditions in communities become more important. So every plan for each of the five objectives really has to include action at each of these levels, because if we can act at the same time and align our interventions we have a much better chance of making a difference.

Moderator: I understand there have been efforts made to quantify or to evaluate how the community factors affect health outcomes as well. Can you talk to us about that?

Dr. Boufford: Yeah. There is a very interesting project out of the Population Health Institute at the University of Wisconsin called County Health Rankings and they have produced a report for each of the states, including New York, over the last three years. This report really tries to illustrate how important community conditions are in influencing the state of health of individuals. So if we look at the diagram that kind of lays out these variables, if we start at the top, the overall score really relates to health outcomes; the mortality rates in a community and the morbidity rates in a community and how they rank within the state. These are developed by equal weightings of what are called health factors. If you look down the middle of the diagram you see the issues of health behaviors, clinical care, social and economic factors, and the physical environment. Each of those is further defined on the right-hand column. So a score is possible for each of these areas and the weighting, as I mentioned, really reflects this pyramid or this impact that we know from acting at the individual level as well as at the policy level. So the scores are aggregated and they yield scores for each county. We can then begin to develop a map, such as you see here, which is the 2013 map of New York State's rankings. The dark green is the counties which are having the worst time with these health and social variables, and many of the causes are often related to poverty. These are important issues that require concerted action within the community, and also the kind of policy support that we hope the Prevention Agenda will motivate.

Moderator: This is a helpful way to conceptualize what you're talking about and see in green on our slide, but in black and white, really, how these issues affect different communities. You've got this broad partnership of all these people invested in the Prevention Agenda. What do you really hope to accomplish?

Dr. Boufford: Well, this broad-based group that I mentioned was developed for four goals for the plan. We want to see certain things happen while this process is ongoing. The first is the overall purpose, which is to improve the health status of all New Yorkers in the five selected areas, and especially to tackle the issue of health disparities. We sort of agree on a vision of making New York the healthiest state, as you said, getting it out of the middle of the pack. The second goal is really to begin to tackle these broader determinants of health and the term "Health in All Policies" is often used to reflect the fact that in the areas of agriculture, food safety, housing, transportation, air quality, or built environment, there are decisions that can be made. In all of those areas, in a particular program or policy is this going to help promote health? Our job is really to get these other actors to understand how what they're doing can really contribute to the health agenda. The third area is that we want to leave behind a very much stronger public health infrastructure at the state and local level. We know that public health is not as well funded as we'd like. The public health agencies are really pulling together here to get results, including the involvement of the Department of Mental Health, and the Office of Substance Abuse Services which are engaged in the fourth goal area of the state plan. The partnerships that have to be created among all of the actors that we've talked about, we want to see sustained so it isn't a one-off exercise. We want them to get together and submit a report to the state. They really begin to develop relationships and see that working together in the community they can make an enormous difference. Finally, as this diverse ad hoc group sat around, we realized that we

probably weren't making a strong enough case about the importance of public health and prevention. So we really had to think about how to make the case to businesses. How do you make the case to those who aren't as familiar or as committed to our interests? One of the really significant things is, again, an increasing understanding of what you might call the Return on Investment for every dollar invested in community based preventive services on things like tobacco, exercise, and diet that Sylvia mentioned. There's a possibility for all pair savings of almost \$6. This can happen in a fairly short time period, two to five years, and this is a very different understanding of what is the time frame for real prevention results than we've had in the past. So it's very encouraging and gets people motivated.

Moderator: Excellent. So now how does this fit in with other health initiatives at the federal, state, or even local level?

Dr. Boufford: Well, we looked at those because context is everything when you're trying to start an initiative. The first thing we did is really look at the National Health Care Reform, and the Affordable Care Act really does provide a lot of messages and a lot of unprecedented funding for preventive services and this is certainly influencing the state waiver and the state application. We can see that in the Medicaid Redesign Program. So for example, individuals now should be getting age appropriate preventive services without any co-pay regardless of their insurer and that's a huge change. The agenda also tries to align local programming efforts and build up on those programs. For example, the state health department, with state and federal funding, supports programs like healthy heart, or asthma control, or maternal child health initiatives and vaccinations. The Prevention Agenda really hopes to be a call for action to help those groups really see how they can connect their own plans with the state Prevention Agenda, especially in their own communities because that's really the essence of success of this program. The work will be anchored by the Community Service Plan and the Local Health Department Community Health Assessments, which the state has asked the hospitals and local health directors to conduct.

Moderator: Sylvia, can you talk to us a little bit about the local community health planning efforts?

Sylvia: Certainly, and Dr. Shaw talked about this as well. We have required in New York State that local health departments and hospitals conduct community health assessments and planning at least since 1986. What's new this year is that the Prevention Agenda is requiring them to do this collaboratively. The Prevention Agenda provides a blueprint for how to assess health status, identify local priorities and develop a plan for addressing them. We're really hoping it's the toolbox for them to take out in their local communities. At the beginning of this planning process, in December, Dr. Shaw sent out a letter to hospitals and health departments requiring them to work together on this and asked them to identify in their process at least two Prevention Agenda priorities that made sense based on the data in their community. One of them has to address a health disparity. So that's how we're setting it up this year for that local planning.

Moderator: Great, thank you. Some of the work that Sylvia discussed is happening close to us here in the Capital Region. We had the opportunity to speak with Jim Connelly about the U-Matter program at

Ellis Hospital in Schenectady County and some of the great work that they're doing. They recently hosted a press conference to introduce the U-Matter campaign. Let's take a look at that right now.

[Video-Jim Connelly]: Our program, the U-Matter program in Schenectady, actually mirrors a program I first saw in Chicago. The Sinai Health System in Chicago for the past ten years has been engaged in this kind of a program. The principle of it being that there is a great deal of health related data and a lot of different databases, but that data sometimes does not cover significant diseases in the community. In fact, sometimes it masks the diseases that exist in the community, and some of the people who actually are experiencing those diseases don't have anybody to advocate for them and bring those diseases to light. The best way to unmask this data, to bring these things to light, is to do a neighborhood by neighborhood, door by door survey to really assess what people's needs are. I think what's different about this approach is it's not being driven by an institution. This is not an institutional program in assessing the community's health. It is very much driven by the community. The hospitals and other health care providers are facilitating it, enabling it, supporting it, but it is not our particular program. We're not actually conducting the program that's being conducted by a communitywide coalition. It is a door-to-door survey as opposed to just looking at databases and abstract in the data. It's not to say we won't look at the databases, but it's being meshed with person-to-person interviews. The last thing that's different about our initiative is we're actually using people who live in the neighborhoods. We're having neighbors ask neighbors these questions. These very same people who are asking the questions can also be people who help screen the answers. They'll be able to determine when an answer is truly reflective of the same kinds of health issues they're facing and make sure the answers are truthful and accurate. In the long run this will mean that people will not need to use the hospitals as much or be admitted to the ERs as often, and their chronic illnesses will be better managed. That's a good thing in the long run because it will drive down consumption and drive down health care costs. Of course, in the short run that may hurt us because obviously things that we get paid for will disappear, but we just have to adjust our business model. I think this program aligns with the Prevention Agenda because many of the things that the Prevention Agenda called for are sort of cornerstones of this community health initiative- trying to keep the population well. So we are carrying out at the grassroots level all the things that have been identified at the federal and then state and county levels, and then we have worked with the county in the past to roll it out into our community. In terms of the principles of what you're trying to do, it aligns perfectly, I think, with those health principles and health guidelines. In terms of collaboration with the community in creating collaborative community planning processes, this is much better. A lot of time and attention has been paid to this initiative because even though Ellis is involved, even though Hometown Health is involved, even though the Department of Health is involved, it is a community-driven organization. It's very, very apparent that the institutions are not in control of this thing, they're facilitating it.

Moderator: So it's clear to me, at least, that Schenectady County and Ellis Hospital are really doing some great work especially in incorporating the things you guys have both been talking about at working at the community level and getting that collaboration. Sylvia, can you talk about how the five specific priority areas were identified and how local communities can use that information in developing their own or addressing their own priorities?

Sylvia: Certainly. Jo talked a little bit about the ad hoc committee that we had that actually helped identify the five priorities based on that data. Once the priorities were selected, we invited a whole host of additional people, there were over 200, from a wide range of sectors to develop the priority-specific plans. We had excellent participation from colleagues in public health, medicine, community-based organizations, several business representatives, and some media. So we really, again, did that collaboration that made such a difference. We organized these people into five different committees, one for each priority. They were chaired by pairs of people, one from the government sector and one from non-government. They led a process over several intensive months, July through September, to develop priority-specific action plans for each priority. We had a steering committee made up of the chairs of each of those five committees and some other people to address cross-cutting issues and to keep us moving. We were funded in part by The Robert Wood Johnson Foundation, which supported our efforts.

Moderator: Can you describe for me and for the audience, what is in each of the priority action plans?

Sylvia: Certainly. We developed a set of tools for each priority area and they include the following. For each priority area we have focus areas, we then have goals, measurable objectives or metrics for each of the goals, and a set of evidence-based interventions. Those are sorted both by the sector, or the stakeholder group, and then by the health impact pyramid that Jo talked about. Before walking you through an example of this tool for the chronic disease priority, I want to spend a few minutes to talk about intervention.

Moderator: Sure, I think that would be great.

Sylvia: The list of interventions is evidence-based approaches for consideration. The purpose was to suggest actions for consideration at the local level, but not to be prescriptive. Included in the list of interventions are the background resources where you can learn more about them and how to adapt them in your community. Each community is going to consider its own circumstances before selecting the interventions from the menu that we provided. We are anticipating that partners sitting around these local tables will expand and refine the lists through their implementation. Now, I want to walk through a complete example of one priority area for chronic disease, so you can see what's included.

Moderator: Sure, I think that would be really helpful to illustrate how this will all come together.

Sylvia: Okay. So for the Prevent Chronic Disease priority, there are three focus areas. The first has to do with reducing obesity in children and adults, the second has to do with addressing tobacco, tobacco use and secondhand smoke, and the third has to do with increasing people's access to high quality chronic disease prevention and management in both clinical and community settings. So I'm going to talk about reducing obesity in children and adults, which as you saw in the other slide is a huge factor in contributing to illness in New York State. One of the goals for the reduce obesity in children and adults is to create community environments that promote and support healthy food and beverage choices and physical activity. That's the goal area there, and we have several objectives for this goal. I'm showing you here just one. We have an overall objective for adults, which you can see is to reduce by 5% the

rate of obesity. Then we have some sub-objectives, one for those people with low incomes under \$25,000 and another one for people with disabilities. Again, you saw the previous slide on disparities that people with disabilities suffered disproportionately from obesity so we wanted to have a specific measurable goal so we can track our progress in addressing it. Then we move on to interventions. For the particular focus area of reducing obesity in children and adults, we have sort of the interventions by that pyramid that Dr. Buford discussed earlier. So, what you're seeing here is the top of the pyramid. Here are some of the interventions for reducing obesity in children and adults. In the second level clinical interventions, we want those in the clinical field to increase the capacity of primary care to implement screening prevention and treatment measures for obesity. Again, there are many more interventions in the plan. These are just a couple you could choose from. Then the next slide shows you the bottom of the pyramid, where you can see interventions to implement that relate to changing the context to make individual decisions healthy. Jo spoke about this. This is about improving the community so people can make the healthy decision. In this case, we focused on business models that support increased use of healthy, locally-grown food. The socioeconomic factors, which as difficult as it might be to address, we have to focus on as well. It's best to intervene in as many levels of the pyramid as possible to have the biggest effect.

Moderator: And there are interventions by sector as well?

Sylvia: Yes. So we also sorted them the second way by sector. When developing a local plan, those community groups at the table will be able to say, "If I'm a health care representative, here's something I can do- adopt hospital policies to change the food we serve in our cafeteria to both the public that comes in and to the patients who are served in that hospital." That's a huge effort.

Moderator: Sure.

Sylvia: Media can support us by doing public service announcements to promote healthy eating or breast-feeding. Then you can see the other slides as well. There are interventions for academia, for government agencies, and for the non-governmental sector, policymakers who are very important, communities, and philanthropy. We really identified an evidence-based or a promising practice for each of the sectors that we hope will play a role in these community collaborations.

Moderator: It seems like it's very well laid out. A nice linear format for people to follow along and say, "Okay this is our goal, how do we get from point A to point B?"

Sylvia: That's right, that's what we're hoping for. We hope it's a useful document. The final slide I wanted to share with you is back to the pyramid, where you can see all the sectors that we really want to engage. Here you see all laid out what each sector's role can be in addressing obesity prevention. It's also another way to summarize what we've done.

Moderator: I think looking at it that way, it's a very helpful way for folks to see where exactly they fit into the picture of moving things forward toward the goals of the Prevention Agenda. I think that was a very helpful look at how chronic disease is being addressed through the Prevention Agenda. At this point, I think it would be helpful to turn to an example of Schenectady County and their ARC and how

they've implemented a program to some of the interventions we've discussed. Let's take a moment to listen to staff and participants in that program.

[Video- Staff Member]: This project really relates to the decreasing chronic disease Prevention Agenda item that is one of five items on the Prevention Agenda. Here at Schenectady ARC we're working with a group of individuals who are developmentally disabled that are disproportionately affected by chronic disease. This project really looks to mitigate that chronic disease by increasing our access to fresh produce. The pilot program that started in 2010 involved around 70+ individuals. It varied depending on the stage of the program. At the end of the program we found that the vegetables were distributed to almost every group home we have and there are 21 group homes operated by Schenectady ARC, as well as our day programs. They were sent home to the group homes, they were sent to family homes as well our participants living with their families or caregivers, and they went back to the day programs. So we benefited an incredible number of our participants through this program. We did note that they tended to want to eat vegetables on a more regular basis.

[Video- Participant]: We've got 20 houses and we try to send them to each house and I can see they eat healthier because they ask for vegetables now. I love it here. It relaxes me so much. I grow vegetables, flowers, and I get my hands dirty.

[Video- Staff Member]: The collaboration between Schenectady ARC and Schenectady County Public Health Services is a new partnership that we've developed over the last three years that has proved invaluable to us in the Strategic Alliance for Health. They've really taken their experience with horticulture and spread it throughout the community and have been working with other partners as well. 'Know, Grow, and Eat Your Vegetables' is a very economical program. We have a horticulture coordinator who works side-by-side with the participants through the entire growing process, teaching them how to cultivate a plant, water a plant, and harvest a plant. That's part of the requirement and that's an in-kind expense through our agency so that individuals providing that service become part of our day program. We obtained a small grant from the Schenectady County Strategic Alliance for Health and we proceeded to create the 'Know, Grow, and Eat Your Vegetables' program.

[Video- Participant]: Before I started here, I was eating bad, really bad, and after I came here and we started eating—now I'm eating greens. My health very much improved just by gardening and learning how to eat better. I can do a lot more stuff and I can eat a lot better and I don't eat garbage.

[Video- Staff Member]: We're really looking at designing our Community Health Improvement Plan through a health equity lens, and looking at populations that are underserved and highly affected by these chronic diseases. These innovative programs allow us to do that.

Moderator: It was really great for us to be able to go out there and talk to both those who started the program, who are working in the program, and even the folks who are participating in the program. I think it really helps to put a face on how this plan is coming into action. Let's take a moment now to move beyond just chronic disease and talk about some of the other priority areas.

Sylvia: Certainly. One of the priority areas that was new to include in the State Health Improvement Plan was the Promote Mental Health and Prevent Substance Abuse priority area because it's not something usually that we in the health field think that we can address. This was really a great collaboration with the Office of Mental Health and the Office of Alcohol and Substance Abuse, and many

other stakeholders in this arena. Mental and emotional well-being are essential to overall health, and many communities tell us we have to include it in our plan. Nationally at any given time, almost 1 in 5 young people is affected by a mental, emotional, or behavioral disorder. We really needed to address this and we're pleased that it's part of this plan. We're really focusing on prevention, not treatment in this plan.

Moderator: Excellent, and what about a goal around preventing infection or disease?

Sylvia: Yes. So, as Jo said, this is one of the more traditional public health issues, but we've combined many of these into one here. We had, again, a broad range of stakeholders helping us address this, so we hope we can move the needle on this. New York remains at the epicenter of the HIV epidemic, ranking first in the number of persons living with HIV/AIDS. The same behaviors and community characteristics associated with HIV also place individuals in communities at risk for STDs and viral hepatitis. While high immunization rates, of course, have been a goal forever in New York State, we're below the national goals on our immunization rates for very young children. That's why this needs to continue to be a priority. We're focusing on healthcare-associated infections at this time as well because they're preventable and we continue to experience a large number of infections and associated deaths with those.

Moderator: Sure, and what about promoting health in women and infant children?

Sylvia: Included in this priority area is recognition that key population indicators for this area have been stagnant recently. This area includes goals related to reducing pre-term births and maternal mortality, promoting breast-feeding, increasing use of comprehensive child health services across the state, reducing dental issues which is huge and preventable, preventing unwanted pregnancies for both teenagers and women, and really focusing on women's health, not just maternal health, but increasing use of health care and appropriate prevention for women of all ages and all stages of their life.

Moderator: And what about, I know we had some discussion earlier about the role of environment and what that plays into. It's not just the characteristics you're born with, but there are these environmental factors. How does that fit into the priority areas?

Sylvia: The Promote a Healthy and Safe Environment tackled some of the more traditional environmental health issues such as air quality and water quality, but also tackled the environment we build around ourselves from homes, to workplaces, to roads and parks. So they're really talking about the built environment, climate change, and focus on super storm Sandy, a really important priority area. They also, as Jo mentioned, included the word "safe" in this to focus on reducing both intentional injuries related to violence, and unintentional injuries, especially as people age. This is an important priority for many communities around the state.

Moderator: It sounds like a lot of thought went into these priorities. They certainly seem to be right on point with everything you've been discussing so far, but also seem very ambitious. What are the plans to measure progress on these goals?

Sylvia: Measurement and accountability are at the heart of this effort. Each committee with tremendous support from our Public Health Information Group staff at the health department worked to identify relevant indicators for each focus area and came up with measurable objectives. There are many measurable objectives in the plan. We'll track 58 of them annually, so we'll be able to report on those and keep track of our progress.

Moderator: And what data on health indicators are available to counties to help them in their planning?

Sylvia: The data that are available for counties are available on our website. We've identified data both at the statewide level and the county level. So what you're going to see on the slide is an example of a Prevention Agenda county dashboard for Albany County, and there's one for every other county in the state. The link is on the slide. The table contains data for 65 individual prevention agenda tracking indicators with baseline county data, comparable state data and the overall state targets for the end of the 5 year period. So there's links to data tables, there's links to maps so you can better visualize what's going on in your county compared to other counties.

Moderator: Excellent, is there a Prevention Agenda website as well that you wanted to share?

Sylvia: Sure, there is indeed. We've been working hard on improving this. This is the part of the website that you see here, and what the arrows show you is how to get those dashboards and the data.

Moderator: Excellent. Just a reminder, we know that some of the images can be hard to see on the screen as it is broadcast to you, but all of the handouts are available on our website as well if any of it is not so easy to be seen on the screen. Now, it seems like there's been a tremendous amount of work that's gone into developing the plan, but when we look at what the plan has laid out, I would imagine a lot of the really hard work is going to come in the implementation. So can you talk to us a little bit about that?

Dr. Boufford: Yeah, that's really a focus of what I said earlier. One of the things we found out the last time around is that many communities had difficulties and challenges. The work that Sylvia and her colleagues have done to create these amazing resources I think will help, because people can take them and adapt them to their own situation. While grounded in the hospital and local health department responses, because of the state requirements, we've started a broad communications plan which begins with the hospital. So a greater New York Hospital Association, HANYS, NYSACHO, and the New York State Association have already begun webinars really explaining to their members and constituencies about the Prevention Agenda and the roles that they can play. There have been broad-based presentations and consultations throughout the state to multiple audiences. We've been really gratified at how the ad hoc leadership group has invited folks from the health department and from their colleagues to come and talk about the Agenda. The health department will also be rolling out a communications plan which has been funded by the Johnson Foundation and with support from the Raven Martin Firm who are experts in the communications processes, we hope to really engage all of these multiple sectors in ways that help them help us understand what health means to them when you talk about it, and then help them understand the role that they can play at the local level. The steps in

the plan really start with the idea of understanding the health concerns of some of these other groups. So in the slide that you'll see, the first step is really having conversations and really understanding what do they mean by health and what are the issues that are going to happen. The second step was really developing a strategy to identify statewide and national opportunities to promote the Prevention Agenda. A third step is developing a tool kit, which we hope will also be very helpful to communities in addressing health disparities. A set of media spokespersons from each of the sectors will be identified and trained, and we hope to get them on the circuit and get them around so they can really share the message with the communities. Finally, as you've seen, there will be continuous development of web content and media, and we'll be seeking additional funding to really make the websites more interactive and capable of collecting the good practices going on around the state in each of these areas , and sharing it across communities.

Moderator: Excellent, and one of the other things you had mentioned was technical support. Can you talk about that a little bit?

Dr. Boufford: Yeah, again, really looking at what wasn't available the last time, a proposal has been put out by the health department asking for organizations that can operate either at the regional or statewide level to provide support to local community health coalitions in their work on the Prevention Agenda. So they will use multiple techniques, meetings, we hope some in-person and webinars. The key topics will be coalition building and the challenge of developing and sustaining partnerships, especially the kind of broad-based partnerships we want to see. Identifying priorities and using the data sets that are available to them to make it easier to identify and design interventions. Then finally, using the Continuous Quality Improvement approach to the testing and implementation, and especially the measurement of performance on this agenda. So all of this work will be going on over the next nine months, as the plans are really being developed. We hope to be able to continue, again, with additional funding the technical support during the implementation phase. We've developed a very important partnership between the Public Health Council and the Minority Health Council on really working together to tackle the issue of health disparities and develop specific framework and tools that local communities can use for that purpose.

Moderator: Now, you've both covered a tremendous amount of information today, so is there a place where people can go for more information on New York State's Prevention Agenda?

Dr. Boufford: Yeah, the home page of the New York State Health Department now has on it a very big blue button which we worked very hard to get there. That should really be seen as your portal to the Prevention Agenda. Push that button and you're in, and you can access all the materials that Sylvia's shown and that have been discussed about each of the five priority areas. Then, there are a series of other resources in subsequent slides here to begin to answer some of the questions. Some of them come from the state health department and others very importantly come from other hospital associations, community health organizations at the national and regional level, and then in the next slide on data resources, again, the county rankings data, videos that may be available, obviously the records of telecasts and broadcasts like this will be available for the use of local communities. We really hope to continue to develop the capability and flexibility of the website to serve the purposes of those

who will be working so hard together, and really breaking ground in very important ways to implement the Prevention Agenda.

Moderator: Great, thank you so much, both of you, for all of the information you've covered.

Dr. Boufford & Sylvia: You're very welcome.

Moderator: We do have a couple of questions that we've gotten, so if you don't mind, the first was, "How Would you Describe a Health Disparity? I live in a county that's predominantly white and I need clarification on how this information regarding health disparities affects me and relates to my county."

Sylvia: That's a very good question. Thank you, whoever asked it. Health disparity is really defined as the difference in health status between different population groups. Sometimes it's measured by just the difference, sometimes the ratio of difference- you can do it different ways. Really what's important here is we're talking about different population groups, not just racial ethnic minorities or majorities in some counties. We're talking about socioeconomic status, which is very important, especially in rural communities. We're talking about people with disabilities. We're talking about zip codes in some areas. So people who live in one part of town versus another part of town. If people can demonstrate that disparity, sometimes it might be related to transportation or access to the service. So I think people can describe and define the disparity, how it makes sense in their community. We're certainly not just talking about race or ethnicity.

Moderator: I think that's a helpful way to clarify that. We have another question, "What were some of the challenges that you saw in creating partnerships at the local level?"

Dr. Boufford: Well, I think in talking with people who have been at this, this is the first round, and we're happy to hear I think this is changing. Originally in some communities, hospital leadership and the local public health leadership had never really talked to each other. Sometimes they didn't know who the other one was. So I think in the first round of the Prevention Agenda, a lot of those barriers were broken down, and hopefully some of those relationships have been sustained and are going to make it much easier in the next round. I think the work of the hospital associations and the public health associations in really raising the profile of the agenda and the importance of these partnerships is kind of the anchor in communities, and is going to be very important. The second challenge, which the ad hoc committee has been very concerned about is how do we bring those other groups that were in the bubbles that you've looked at to the table? So we're hoping by also involving the state level networks of those organizations and community groups, and individuals really, that they will then be able to tap into the local chapter, to the local individuals, and really begin to come to the table and knock on the door of the local hospital's director, or the public health director and say, I understand this Prevention Agenda is going through, I'm working on obesity, I'm working on heart disease, I'm working on food safety, and I want to be in the conversation, and that those will be sustained so it's going to be a lot of work. We know some communities are already doing it very successfully.

Sylvia: Schenectady, for example.

Moderator: Yes, that's a great example of people working in the right direction.

Dr. Boufford: We're heard that going through. The hope is that those that are working well will be able to spotlight what they're doing and they can share their experience with their colleagues and make it easier for the others.

Moderator: Excellent, it seems like a lot of really great work is going to start happening. There's been a lot of work that went into developing the plan. I thank you both so much for sharing all of this with our viewers. I think it's been tremendously helpful.

Sylvia: Thank you.

Dr. Boufford: Thanks for the opportunity.

Moderator: Sure, and thank you very much for joining us today. Please remember to fill out your evaluations online, your feedback is always helpful to the development of our programs and continuing education credits are available. To obtain nurse continuing education hours, CME and CHES credits, learners must visit www.phlive.org and complete an evaluation and the post-test for today's offerings. Additional information on upcoming broadcasts and relevant public health topics can also be found on our Facebook page. Don't forget to like us on Facebook to stay up to date. As a reminder, you can also download the companion guide to this broadcast on our website at www.phlive.org. The companion guide will provide you with learning activities to help further your knowledge and understanding of topics covered in today's program. This webcast will be available on demand on our website within two weeks. Please join us for our next broadcast on April 18th. I'm Rachel Breidster, thanks so much for joining us on Public Health Live.