Strategic Assessment of New York State's Regional Population Health Investments

MAY 2017

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Contents

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Executive Summary

New York State is often cited as a national model in public health because of its strong support for improving the health of its population.[1,2,3] Compared with other states, New York has the sixth-highest per capita expenditure ($94.90) for public health, nearly three times the median of all states ($33.50), according to the Trust for America's Health. This standing is not new: New York State has been ranked in the top 10 states, and often in the top 5, for per capita public health spending since the Trust's first annual report was published in 2009. Such funding is critical to the health of New Yorkers, as recent studies have found that states with a higher ratio of social and public health spending to health care spending had significantly better health outcomes for their populations.[4]

New York State has a well-defined strategy for pursuing population health through its 2013–2018 Prevention Agenda, and it has aligned State policy and grant funding to achieve its goals. The Prevention Agenda serves as the blueprint for State and local action to improve the health of New Yorkers in five priority areas and to reduce health disparities for racial, ethnic, disability, and low socioeconomic groups, as well as other populations who experience them.[5] New York State also is taking on major transformation initiatives within its $8 billion Medicaid Delivery System Reform Incentive Payment (DSRIP) program and its $100 million State Innovation Model (SIM) initiative. Both DSRIP and SIM address population health through quality measures and efforts to enhance care coordination within the safety-net and primary care spaces, respec-

[1] Trust for America's Health. Investing in America's Health: A State-by-State Look at Public Health Funding and Key Health Facts, 2016. Available at: **http://healthyamericans.org/assets/files/TFAH-2016-InvestInAmericaRpt-FINAL.pdf**, accessed April 2017.

[2] Knickman, J.R. Making New York the Healthiest State: A Population Health Summit. *Health Affairs* Blog, 2013. Available at: **http://healthaffairs.org/blog/2013/12/12/making-new-york-the-healthiest-state-a-population-health-summit/**, accessed April 2017.

[3] Association of State and Territorial Health Officials (ASTHO). Georgia and New York Health Departments Receive America's Health Rankings Champion Award from ASTHO and United Health Foundation, 2014. Available at: **http://www.astho.org/Press-Room/Georgia-and-New-York-Health-Departments-Receive-Americas-Health-Rankings-Champion-Award-from-ASTHO-and-United-Health-Foundation/9-11-14/?terms=new+york+population+health**, accessed April 2017.

[4] Bradley, E., Canavan, M., Rogan E., Talbert-Slagle, K., Ndumele, C., Taylor, L., Curry, L. Variation In Health Outcomes: The Role Of Spending On Social Services, Public Health, And Health Care, 2000–09. *Health Affairs*, 2016, 35(5), 760–68.

[5] New York State Department of Health. Prevention Agenda 2013–2018: New York State's Health Improvement Plan, 2016. Available at: **https://www.health.ny.gov/prevention/prevention_agenda/2013-2017/**, accessed April 2017.

tively. It is important to align all these efforts as much as possible so as not to add layers of complexity to an already complicated funding and delivery system. To maximize the value of the State's investments, stakeholders should be clear on their roles in the overall State population health strategy, how resources are being allocated within New York State's communities, and how they can create synergies from these investments.

This report seeks to analyze the New York State Department of Health's (NYSDOH) current funding for total population health and make recommendations about how the State and its residents can gain more value for funds spent on achieving the Prevention Agenda. The key questions this report addresses are:

- How much funding is being provided to meet New York State's various Prevention Agenda goals?
- Which entities are receiving these grants?
- How can New York State's existing efforts be organized to maximize the State's investments in population health and grantmaking?
- How can population health efforts and funding be better synergized, promoted, and coordinated by New York State?

To answer the first and second questions, data from the NYSDOH were requested for State fiscal year (SFY) 2015–16 on grants related to Prevention Agenda priorities. In 2015–16, New York State appropriated $1.5 billion in funds to be spent on these grants, with 58% of these funds coming from federal sources, 41% from the State, and 1% from private funding. As New York State's per capita spending on population health is triple the national state median and 60% of State nonoperations spending comprises federal funds, it appears that the State has been very effective in its efforts to secure competitive federal funding streams. However, federal funding can be rigid. Because the U.S. Centers for Disease Control and Prevention and other federal agencies attach specific requirements to their funding streams, federal decision-making can sometimes result in a siloed approach.

Of this $1.5 billion in total spending, the majority was allocated to public health capabilities (69%), which include surveillance and epidemiology, preparedness and response activities, food pro-

grams, and other core public health activities. The next two largest allocations were for (1) preventing HIV/STDs, vaccine-preventable diseases, and health care-acquired infections (15%); and (2) promoting healthy women, infants, and children (10%), as shown in Table 1. Preventing chronic disease (5%) and promoting a healthy and safe environment (1%) received smaller proportions of the funding. Of this $1.5 billion, nearly two-thirds ($1 billion) was allocated to services that can be characterized as direct services (school-based clinics, the SNAP and WIC food programs, Ryan White Part B, the public health emergencies fund, Indian health services, and the vaccines for children program), and one-third ($500 million) is allocated to prevention in the community.

TABLE 1. SFY 2015–16 Funding by Prevention Agenda Priority Area

PREVENTION AGENDA SPENDING BY PRIORITY AREA	2015–16 APPROPRIATION	PERCENT
HIV, STDs, Vaccine-Preventable Diseases, Health Care-Acquired Infections	$226,624,713	15%
Chronic Diseases	$80,715,468	5%
Healthy Women, Infants, and Children	$157,130,687	10%
Healthy and Safe Environment	$17,873,000	1%
Mental Health and Substance Abuse*	$722,000	0%
Public Health Capabilities	$1,062,488,570	69%
Total	**$1,545,554,438**	**100%**

*Note: The funding for promoting mental health and preventing substance abuse is understated, as funds awarded through the New York State Office of Mental Health and New York State Office of Alcoholism and Substance Abuse Services are not included in this data set.

A different analysis, related to this report's second goal, examines Prevention Agenda-related grant awards that received funding in SFY 2015–16; these data do not match up with the appropriations data described above because (1) some funding was not spent as grant awards and (2) not all funds appropriated in each year are awarded by NYSDOH or expended by its grant contractors. The 1,566 grant awards included in Table 2 account for $838,441,920 of the spending in SFY 2015–16. For the 54% of grants (852) in which a county catchment area was assigned, there appears to be a correlation between the population of a county and the number of grant awards: the bigger the county, the more grants. The median number of grants per county is 7 for single-county awards and 21 for multicounty awards. Some counties, disproportionate to

their population size, have had more success than others in securing competitive grant funding for population health. That success is likely a result of the actions of strong local health departments or community integrator organizations (such as population health improvement programs and rural health networks), which have helped communities with strategic planning, grant writing, and administration.

Recipient types were not provided as part of the SFY 2015–16 grant data set. But through manual coding and review, 1 of 9 entity types were assigned to 921 of the 1,566 grant awards. These 921 accounted for 59% of the grant awards and 69% of the grant dollars. Although counties received the highest number of grants (462 awards), they obtained only 18.7% of the funding. At the same time, hospitals secured 227 grants, which accounted for 22% of the total grant funds.

TABLE 2. 2015–16 Public Health-Related Grant Awards by Entity Type

ENTITY TYPE	# GRANT AWARDS	FUNDING TOTAL	% OF TOTAL
Counties	462	$156,415,239	18.7%
Hospitals	227	$184,693,740	22.0%
Federally Qualified Health Centers	96	$44,440,636	5.3%
New York City Department of Health and Mental Hygiene and City Entities*	23	$162,113,318	19.3%
Rural Health Networks	38	$10,022,471	1.2%
Population Health Improvement Programs (PHIPs)	12	$8,578,692	1.0%
The State University of New York (SUNY)	26	$7,101,441	0.8%
University	16	$6,921,388	0.8%
Boards of Cooperative Educational Services (BOCES)	21	$1,190,094	0.1%
Subtotal for Assigned Entity	921	$581,477,019	69.4%
Community Organizations and Other Unassigned	645	$256,964,901	30.6%
Total	**1566**	**$838,441,920**	**100.0%**

* New York City Entities include Public Health Solutions and the Fund for Public Health in New York City

To gather input on how New York State can maximize the value of these grant funds, 13 in-depth, qualitative interviews were conducted with thought leaders from local health departments, rural health networks, community collaboratives, private foundations, hospitals, government agencies, and policy organizations. A key theme from the interviews emerged: Despite the well-defined blueprint set out by the Prevention Agenda, community-based organizations, local health departments, health care providers, and policymakers are not always clear about their roles in the overall State strategy, how resources are being allocated within New York's communities, and how these stakeholders can create synergies between these investments.

Based on these interviews and the analysis of SFY 2015–16 data, the following recommendations emerged:

1. Provide more resources within NYSDOH to support the operation of the Prevention Agenda framework.
2. Develop, maintain, and make publicly available a population health grant data set.
3. Take a collaborative approach to grant design by further involving community stakeholders.
4. Engage private and community foundations. Consider formation of a philanthropic collaborative to support New York State's population health efforts.
5. Given the critical role they play, invest in community integrator organizations by providing secure base funding and more technical assistance.
6. Provide dedicated funding to increase local health department participation in local and regional collaboratives.
7. Identify a visible, public-facing senior leadership champion for population health within NYSDOH.

As a result of its funding and well-defined agenda, New York State is a national model in supporting population health. The overarching aim of the Prevention Agenda is to make New York the healthiest state in the nation. Implementing these recommendations can help the State get closer to that goal.

Introduction

New York State is often cited as a national model for its support of population health.[6,7,8] Its 2013–2018 Prevention Agenda, developed by the New York State Public Health and Health Planning Council at the request of the New York State Department of Health (NYSDOH), is intended to serve as the blueprint for State and local action to improve the health of New Yorkers in five priority areas and to reduce health disparities for racial, ethnic, disability, and low socioeconomic groups, as well as other populations that experience them.[9]

The Prevention Agenda has five focus areas to: prevent chronic diseases; promote a healthy and safe environment; promote healthy women, infants, and children; promote mental health and prevent substance abuse; and prevent HIV, sexually transmitted diseases, vaccine-preventable diseases, and health care-associated infections (HAI). Each focus area includes subgoals, which are well-defined. For example, under the goal of preventing chronic diseases, the Prevention Agenda calls for adopting hospital policies to support use of healthy, locally grown foods in cafeteria and patient meals. The Prevention Agenda has been supported by the alignment of State policy and grant funding to achieve its goals.

This report seeks to analyze current New York State funding for total population health and make recommendations for how the State and its residents can gain more value for funds spent. The key questions this report addresses are:

- How much funding is being provided to meet New York State's various Prevention Agenda goals?
- Which entities are receiving these grants?

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[6] Trust for America's Health. Investing in America's Health: A State-by-State Look at Public Health Funding and Key Health Facts, 2016. Available at: **http://healthyamericans.org/assets/files/TFAH-2016-InvestInAmericaRpt-FINAL.pdf**, accessed April 2017.

[7] Knickman, J.R. Making New York the Healthiest State: A Population Health Summit. *Health Affairs* Blog, 2013. Available at: **http://healthaffairs.org/blog/2013/12/12/making-new-york-the-healthiest-state-a-population-health-summit/**, accessed April 2017.

[8] Association of State and Territorial Health Officials (ASTHO). Georgia and New York Health Departments Receive America's Health Rankings Champion Award from ASTHO and United Health Foundation, 2014. Available at: **http://www.astho.org/Press-Room/Georgia-and-New-York-Health-Departments-Receive-Americas-Health-Rankings-Champion-Award-from-ASTHO-and-United-Health-Foundation/9-11-14/?terms=new+york+population+health**, accessed April 2017.

[9] New York State Department of Health. Prevention Agenda 2013-2018: New York State's Health Improvement Plan, 2016. Available at: **https://www.health.ny.gov/prevention/prevention_agenda/2013-2017/**, accessed April 2017.

- How can New York State's existing efforts be organized to maximize the State's investments in population health and grantmaking?
- How can population health efforts and funding be better synergized, promoted, and coordinated by New York State?

This analysis of community population health funding will allow New York State and community stakeholders to maximize the State's investment. Such an effort is particularly critical now that the State is taking on major transformation initiatives within its $8 billion Medicaid Delivery System Reform Incentive Payment (DSRIP) program and its $100 million State Innovation Model (SIM) initiative. Both DSRIP and SIM address population health through quality measures and efforts to enhance care coordination within the safety-net and primary care spaces, respectively. It is important to align these efforts as much as possible so as not to add layers of complexity to an already complicated funding and delivery system. To maximize the value of the State's investments, stakeholders should be clear on their roles in the overall State population health strategy; how resources are being allocated within New York's communities and across different local organizations; and how these local organizations can better coordinate their activities.

The Institute for Alternative Futures notes that the public health community is currently situated at the fulcrum of many of society's greatest challenges, and that population health and chronic disease are fraught with uncertainties to which public health will need to respond in the years to come.[10] This policy imperative is made more urgent by the active transformation initiatives—DSRIP and SIM—already underway in New York State. Through analysis of current funding and review of stakeholder input, lessons can be gained about what is working and what is not, and a platform can be created for strategic planning to maximize resources in the future.

DEFINING POPULATION HEALTH

Population health means different things to different constituencies. Government and public health officials are likely to view population health as the health outcomes of all people within their jurisdiction, be it federal, state, or local. Health plans, including Medicaid and Medicare,

[10] Institute for Alternative Futures. Public Health 2030: A Scenario Exploration, 2014. Available at: **http://kresge.org/sites/default/files/Institute-for-Alternative-Futures-Public-Health-2030.pdf**, accessed April 2017.

are likely to think about their own members' health outcomes. Provider organizations, in turn, focus on their own patient or client panels.[11] These disparate population health definitions create a complex set of Venn diagrams where population health interventions and funding streams mix, match, and overlap, as well as create gaps at the state and community level.

This paper focuses on total population health or community population health within a given geography (in this case, New York State) and how the NYSDOH supports population health improvements in a geographic community. The New York Academy of Medicine's Primary Care and Population Health workgroup defines total population health as: "improving the health and well-being of all people in a population in a given geographic area while eliminating health inequities. Substantive partnerships with communities, and across sectors affecting health (including but not limited to public health, health care, housing, education, and social services), as well as shared responsibility/accountability and supportive financing models, are required to achieve these goals." Collaboration and partnerships also play a key role in improving total population health, which requires partners across many sectors (including public health and health care organizations, community organizations, and businesses) to integrate investments and policies across all determinants.[12] Although health care organizations of all types are undertaking population health management for their patients or enrolled members, such management is not a focus of this paper.

Many challenges are associated with implementing population health improvement interventions. It has been noted that one such challenge is that providers, payers, and government agencies often have different ideas about which populations to target; which prevention/health promotion strategies and incentives to employ; and which measures to use to track progress. Thus, parallel efforts emerge that could have benefited from collaboration but instead lack consistency or fail to take advantage of the economies of scale associated with a unified effort. This lack of coordination is also evident in how public health departments and Medicaid programs approach population health improvement.[13]

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[11] Milbank Memorial Fund. Population Health in Medicaid Delivery System Reforms, 2015. Available at: **http://www.milbank.org/uploads/documents/papers/CHCS_PopulationHealth_IssueBrief.pdf**, accessed April 2017.

[12] Kindig, D.A. What Are We Talking About When We Talk About Population Health? *Health Affairs* Blog, 2015. Available at: **http://healthaffairs.org/blog/2015/04/06/what-are-we-talking-about-when-we-talk-about-population-health/**, accessed April 2017.

[13] Milbank Memorial Fund. Population Health in Medicaid Delivery System Reforms, 2015. Available at: **http://www.milbank.org/uploads/documents/papers/CHCS_PopulationHealth_IssueBrief.pdf**, accessed April 2017.

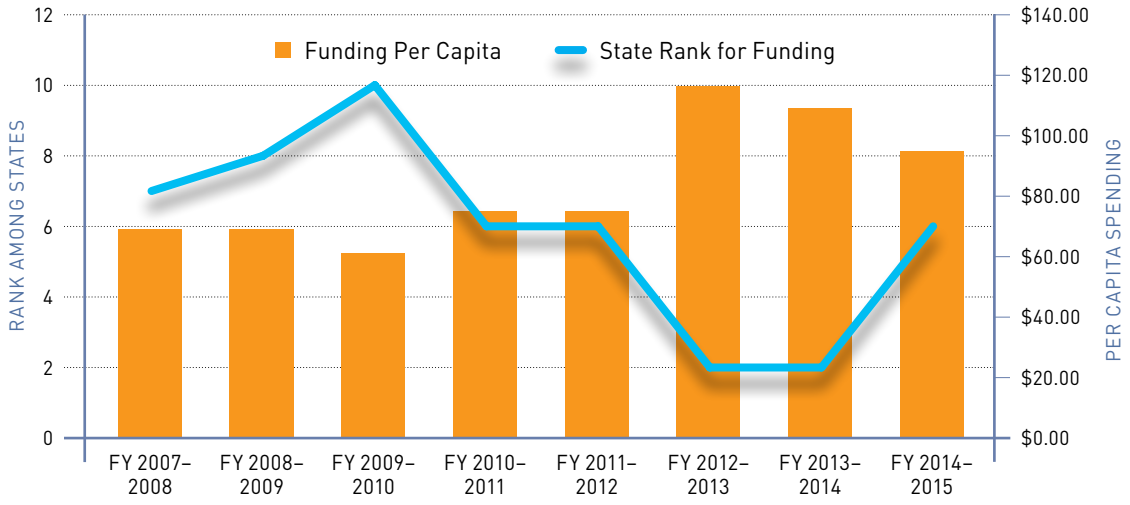
> "I struggle with the population health efforts in New York and how they are implemented. There needs to be a logical sequence and connection to get the dominoes to fall." ***—Interview Respondent***

NATIONAL DATA ON PUBLIC HEALTH SPENDING: NEW YORK IN CONTEXT

Each year since 2009, the Trust for America's Health, with funding from the Robert Wood Johnson Foundation, has issued a report examining public health funding across states. In the 2016 edition, which examines state fiscal year expenditures for 2014–15, New York State has the sixth-highest per capita expenditure ($94.90)—nearly three times the median state per capita expenditure ($33.50). This high ranking is long-standing—New York State has been ranked in the top 10 among states, and often in the top 5, for per capita public health spending since the Trust's first annual report was published in 2009, as shown in Figure 1.

FIGURE 1

New York State Public Health Funding Per Capita and Rank Among States 2007-2015



Source: Trust for America's Health 2009–2016

Based upon these national data, New York State should be viewed as a leader for its efforts to make funds available for public and population health, even though funding levels have dropped in each of the last two years. In fiscal year 2014–15, the Trust shows $1,874,587,954 of public health appropriations in New York, as shown in Figure 2. There are some limitations to the Trust's national analysis that are worth noting. For example, every state presents its budget data in different categories and with varying descriptions for similar items, making comparisons across states difficult. In addition, the Trust analysis defines public health funding broadly, meaning that state-level health funding (not just public or population health) and agency operations expenditures are included in the analysis. It is important to note that the New York State-specific data set analyzed later in this report explicitly excludes NYSDOH agency operations spending and most direct health service expenditures.

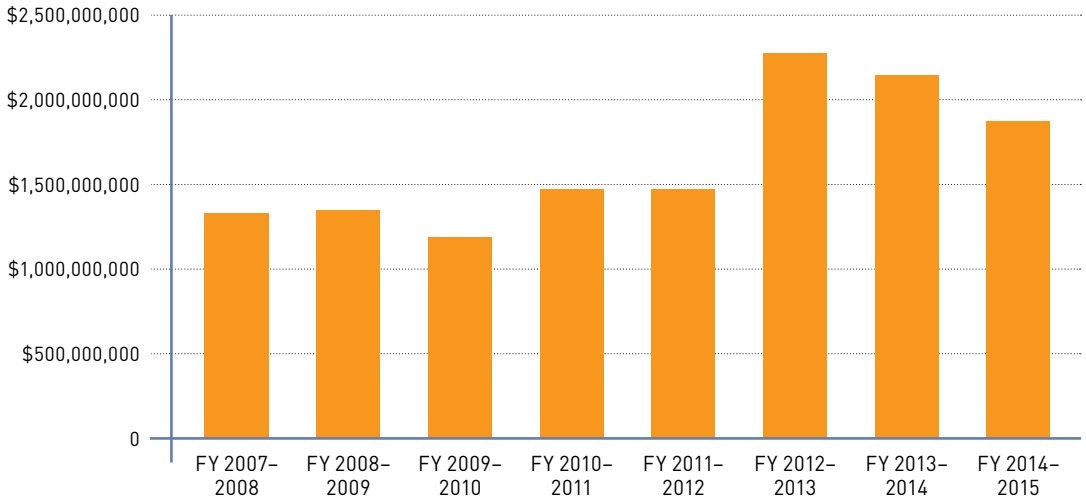
Generally, federal public and population health funds are distributed in discrete categories, and states often must compete for these funds via submission of competitive applications.[14]

As New York State's per capita spending on population health is triple the state median and 60% of the State's nonoperations spending comprises federal funds, it appears that New York State has been very effective in its efforts to secure competitive federal funding streams. However, federal funding can be rigid. Because the U.S. Centers for Disease Control and Prevention and other federal agencies attach specific requirements to their funding streams, federal decision-making can sometimes result in a siloed approach.

[14] Trust for America's Health. Investing in America's Health: A State-by-State Look at Public Health Funding and Key Health Facts, 2016. Available at: **http://healthyamericans.org/assets/files/TFAH-2016-InvestInAmericaRpt-FINAL.pdf**, accessed April 2017.

FIGURE 2

Reported New York State Public Health Budget 2007–2015
(Includes Agency Operations)



Source: Trust for America's Health 2009–2016

Analysis: Prevention Agenda Funding Data Set

As the Prevention Agenda is a keystone of New York State's population health strategy, it is useful to know what grant programs the NYSDOH is funding to support the achievement of the Prevention Agenda's goals. Having a clearer picture of NYSDOH's investments will help ensure the continued positive progress of the Prevention Agenda. It will also provide communities with information on which organizations and initiatives are funded in their areas so as to facilitate greater coordination.

METHODS: COMPILATION OF THE PREVENTION AGENDA FUNDING DATA SET

To conduct the analysis of grant funding in support of Prevention Agenda priorities, a data set was requested from the NYSDOH detailing its spending on priorities associated with the Prevention Agenda. Information was requested for spending that goes into the community and not on NYSDOH operations. Because this information is not assembled in one data set, an intern was hired to work under the supervision of NYSDOH's Office of Public Health Practice to obtain the necessary figures and organize the data. The data fields requested included:

- Source of funding (State, federal);
- The purpose and total amount of the funding;
- The grant recipients and their individual award amounts;
- The county or counties served (when available); and
- The start and end dates of funding.

To compile the data set, NYSDOH obtained State fiscal year (SFY) 2015–16 appropriations data from its fiscal staff; expenditure plans and spending matrices from NYSDOH program staff; and grant contract information from Health Research Incorporated, NYSDOH's fiscal agent for some grants. The spending data collected included federal and State sources and from private foundations for SFY 2015–16.

Analysis: Prevention Agenda Funding Data Set *(continued)*

The NYSDOH categorized spending by the five priority areas of the Prevention Agenda, plus one additional category designated as Public Health Capabilities, for a total of six categories, as follows:

1. Prevent chronic diseases
2. Promote a healthy and safe environment
3. Promote healthy women, infants, and children
4. Prevent HIV, STDs, vaccine-preventable diseases, and health care-associated infections (HAI)
5. Promote mental health and prevent substance abuse
6. Public health capabilities (not a Prevention Agenda priority area)

The sixth category, public health capabilities, includes assessment functions (such as surveillance and epidemiology); preparedness and response activities; efforts to reduce health disparities; non-lab research relevant to the Prevention Agenda; core public health funding not addressed within the Prevention Agenda (e.g., rabies and tuberculosis); food programs; public health workforce development; and efforts to address cancers not specifically included in the Prevention Agenda. Excluded from the data set are: early intervention services, most direct health care services, and health care insurance. In addition, funding deployed by the New York State Office of Mental Health or any other State agency is not included in the data set.

The resulting data lend itself to two sets of analyses. The first analysis tracks NYSDOH appropriations for public health-related community investments in the six categories in SFY 2015–16. The second analysis looks at how those appropriations are distributed via reimbursement or grant awards in SFY 2015–16. The first data set is a snapshot in time of annual spending, whereas the second data set includes multiyear grants between the years 2009 and 2019, but all with a funding year of SFY 2015–16.

SFY 2015-16 APPROPRIATION ANALYSIS

In SFY 2015–16, the NYSDOH distributed approximately $1.5 billion in funds related to the six categories defined above, with 58% of these funds coming from federal sources, 41% from the State, and 1% from private funding. Of this total spending, the majority was allocated to public health capabilities (69%), with preventing HIV/STDs, vaccine-preventable diseases, and HAI (15%) and promoting healthy women, infants, and children (10%) receiving the next two largest allocations. Preventing chronic disease (5%) and promoting a healthy and safe environment (1%) received a smaller proportion of funding, as shown in Table 3. The funding for promoting mental health and preventing substance abuse is understated, as grants awarded through the New York State Office of Mental Health and the New York State Office of Alcohol and Substance Abuse Services are not included in this data set.

TABLE 3. SFY 2015–16 Funding by Prevention Agenda Priority Area

PREVENTION AGENDA SPENDING BY PRIORITY AREA	2015-16 APPROPRIATION	PERCENT
HIV, STDs, Vaccine-Preventable Diseases, HAI	$226,624,713	15%
Chronic Diseases	$80,715,468	5%
Healthy Women, Infants, and Children	$157,130,687	10%
Healthy and Safe Environment	$17,873,000	1%
Mental Health and Substance Abuse*	$722,000	0%
Public Health Capabilities	$1,062,488,570	69%
Total	**$1,545,554,438**	**100%**

*Note: The funding for promoting mental health and preventing substance abuse is understated, as funds awarded through the New York State Office of Mental Health and New York State Office of Alcoholism and Substance Abuse Services are not included in this data set.

Of this total amount, nearly $1 billion is allocated to services that can be characterized as direct services. These nine direct service funding streams include school-based clinics, the SNAP and WIC food programs, Ryan White Part B, the public health emergencies fund, Indian health services, and the vaccines for children program, as shown in Table 4.

TABLE 4. New York State Population Health Appropriation 2015–16: Direct Service Exclusions

PREVENTION AGENDA PRIORITY AREA	FOCUS AREA	APPROPRIATION TITLE	SOURCE OF FUNDING	2015–16 ENACTED
HIV/STDs, Vaccine-Preventable Diseases, HAI	Immunization	Vaccine for Children	Federal	$103,000,000
	Prevent HIV & STDs	Ryan White Part B	Nonfederal Private	$11,715,801
Healthy Women, Infants, and Children	Child Health	School-Based Health Clinics and Health Center Providers	State	$7,932,000
		School-Based Health Centers	State	$10,400,000
		School-Based Health Centers	State	$826,354
	Maternal and Infant Health	Supplemental Nutrition Assistance (SNAP)/WIC	State	$26,255,000
Public Health Capabilities	Health Equity	Indian Health	State	$22,500,000
	Preparedness and Response Activities	Public Health Emergencies	State	$40,000,000
	Food Programs	Hunger Prevention and Nutrition Assistance Program	State	$34,547,000
		Child and Adult Care Food Account	Federal	$247,694,000
		Federal Food and Nutrition Services Account	Federal	$502,970,000
Total				**$1,007,840,155**

Although all these programs are important to population health, for purposes of analyzing the Prevention Agenda, it is helpful to consider New York State's appropriation for prevention after these direct services have been excluded from the data set. When the $1 billion in direct services is removed, a different picture emerges of NYSDOH's total funding for prevention in the community: Two-thirds of spending is allocated to direct services and one-third is allocated to prevention in the community, as shown in Table 5.

TABLE 5. 2015–16 Funding by Prevention Agenda Priority Area: Total and Direct Service Exclusions

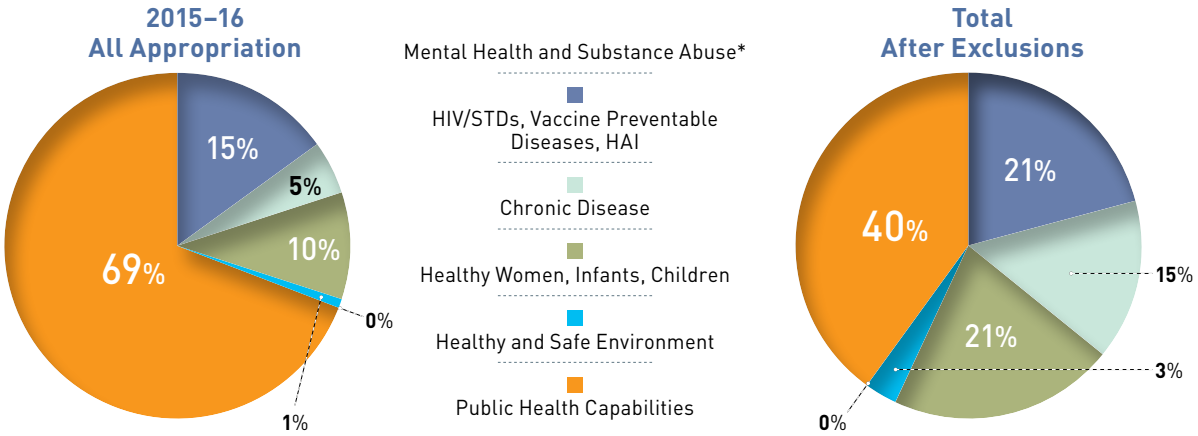
PREVENTION AGENDA PRIORITY AREA	2015-16 APPROPRIATION	DIRECT SERVICE EXCLUSIONS	TOTAL AFTER EXCLUSIONS
HIV/STDs, Vaccine Preventable Diseases, HAI	$226,624,713	$114,715,801	$111,908,912
Chronic Disease	$80,715,468	$0	$80,715,468
Healthy Women, Infants, Children	$157,130,687	$45,413,354	$111,717,333
Healthy and Safe Environment	$17,873,000	$0	$17,873,000
Mental Health and Substance Abuse*	$722,000	$0	$722,000
Public Health Capabilities	$1,062,488,570	$847,711,000	$214,777,570
Total	**$1,545,554,438**	**$1,007,840,155**	**$537,714,283**

*Note: The funding for promoting mental health and preventing substance abuse is understated, as funds awarded through the New York State Office of Mental Health and New York State Office of Alcoholism and Substance Abuse Services are not included in this data set.

With the subtraction of direct service grants—$847 million from the public health capabilities; $114 million from HIV/STDs, vaccine-preventable diseases, and HAI; and $45 million from healthy women, infants, and children—the distribution of grant spending appears slightly more even across categories, as shown in Figure 3.

FIGURE 3

New York State Prevention Agenda Spending by Category: Total and with Direct Services Excluded



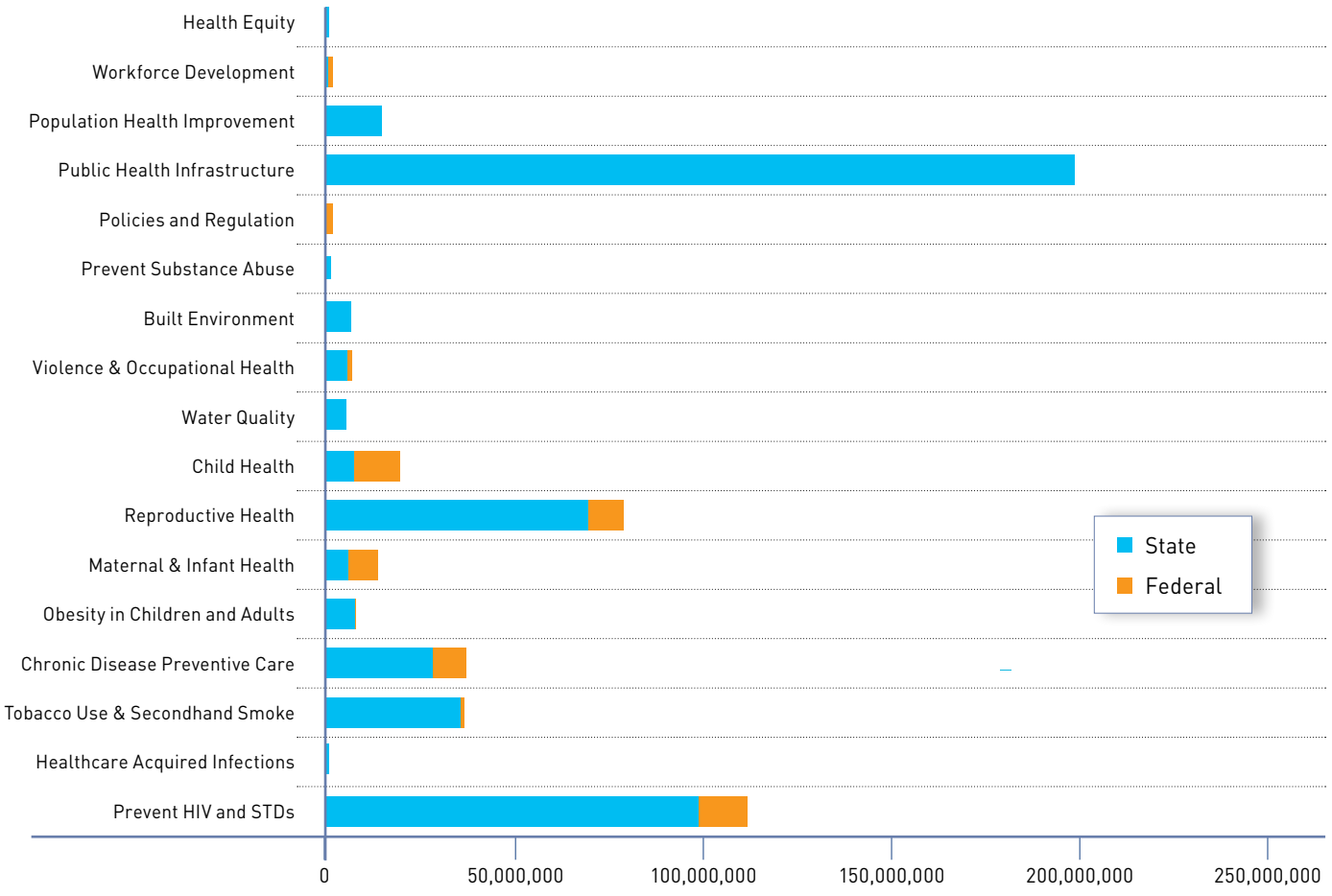
*Note: The funding for promoting mental health and preventing substance abuse is understated, as funds awarded through the New York State Office of Mental Health and New York State Office of Alcoholism and Substance Abuse Services are not included in this data set.

Analysis: Prevention Agenda Funding Data Set *(continued)*

As illustrated in Figure 4, public health infrastructure receives the preponderance of funds in the Prevention Agenda focus areas, followed by preventing HIV and STDs. On the other end of the spectrum, health equity, workforce development, and HAI receive $500,000 per year in prevention spending. Appendix 1 provides a detailed table of SFY 2015–16 appropriations, including appropriation title, funding source, and amount.

FIGURE 4

SFY 2015-2016 Appropriations by Focus Area (Direct Service Excluded)



Although New York State's public health appropriations are relatively high as compared with other states, these appropriations rely on an annual budget approval process—as a result, their ongoing support is at risk. In January 2014, Massachusetts award its first set of grants for population health efforts funded through its Prevention and Wellness Trust. The Trust is funded not by taxpayers but as a one-time assessment on the state's large insurers and large hospitals.[15] As one of its goals, the Trust takes a broad geographic view of population health and funds initiatives that link public health activities with the provision of clinical care. Policymakers in New York State are watching the progress of Massachusetts and its Trust with interest to see if it could be a model for the State. For example, the CUNY School of Public Health and Health Policy, through a New York State Health Foundation-funded grant, is conducting a study to develop a plan and approach for establishing a Wellness Trust for East and Central Brooklyn.[16]

GRANT AWARD-FUNDING ANALYSIS

The second analysis looks at Prevention Agenda-related grant awards that received funding in SFY 2015–16. There are 1,566 grant awards included in this data set. Many of these are multiyear grants with start and end dates ranging from 2009 to 2019, respectively. The total funding amount for the 1,566 grant awards in SFY 2015–16 was $838,441,920. These data are not identical to the SFY 2015–16 appropriations described earlier in this section because some appropriations were not spent as grant awards (e.g., vaccines for children) and not all funds appropriated in each year are awarded by NYSDOH or expended by its grant contractors in that same time frame.

Grant Awards by Geography

A geographic area was assigned to 940 (60%) of the 1,566 grant awards. In nearly all cases, the assignment was to a county region, but 88 of the assignments were for noncounty designations, namely, statewide or regional. The remaining 852 (54%) of the 1,566 grant awards

[15] Massachusetts Prevention and Wellness Trust. An Innovative Approach to Prevention as a Component of Health Care Reform, 2013. Available at: http://www.northeastern.edu/iuhrp/wp-content/uploads/2013/12/PreventionTrustFinalReport.pdf, accessed April 2017.

[16] New York State Health Foundation. Wellness Trust for Brooklyn, 2017. Available at: http://nyshealthfoundation.org/our-grantees/grantee-profile/research-foundation-of-the-city-university-of-new-york, accessed April 2017.

had a geographic area assigned by county. The following analysis thus provides a picture of funding by county, but can only provide a partial picture of how prevention-related grants are distributed to communities.

There were 504 grants awarded to a single county; the other 348 grants were given to multiple counties. Table 6 shows the number of grants per county, both by single and multicounty awards, and also lists the county's population for 2015 and its County Health Ranking for 2015. As one would expect, there appears to be a correlation between the population of the county and the number of grant awards (see Figure 5). The counties of New York City (Bronx, Kings, Queens, Richmond, and New York), along with other urban counties (Erie, Monroe, Onondaga, Albany, Schenectady, Westchester, and Nassau), received more grants than other counties. It should be noted that the data set does not enable analysis of grant funding per capita at the county level because the multicounty grant awards do not specify the amount of funding going to each individual county.

The median number of grants per county is 7 for single county awards and 21 for multicounty awards. Some counties have had more success than others in securing competitive grant funding for population health, disproportionate to their populations. That success is likely a result of the actions of strong local agencies or integrator organizations that help communities with strategic planning, grant writing, and administration. For example, Washington County (population of 62,230) participates in 5 single-county and 28 multicounty grants, and Clinton County (population of 81,251) has 11 single-county and 34 multicounty grants. Conversely, higher-population counties, such as Jefferson (population of 117,635) and St. Lawrence (population of 111,007), have fewer grants: 4 single-county and 16 multicounty awards for Jefferson County and 5 single-county and 15 multicounty awards for St. Lawrence County.

TABLE 6. NYSDOH Grant Awards to Counties Ranked by Health Outcome

COUNTY NAME	SINGLE COUNTY GRANTS	MULTICOUNTY GRANTS	ALL GRANTS	POPULATION	HEALTH OUTCOME RANK
Bronx	15	53	68	1,455,444	62
Sullivan	8	12	20	74,877	61
Cattaraugus	9	16	25	77,922	60
Greene	4	19	23	47,625	59
Chautauqua	11	15	26	130,779	58
Erie	25	18	43	922,578	57
Broome	14	13	27	196,567	56
Niagara	8	17	25	212,652	55
Hamilton	5	7	12	4,712	54
Franklin	4	13	17	50,660	53
Kings	16	66	82	2,636,735	52
St. Lawrence	5	10	15	111,007	51
Chemung	7	14	21	87,071	50
Schenectady	14	23	37	154,604	49
Allegany	8	15	23	47,462	48
Fulton	4	15	19	53,992	47
Montgomery	4	21	25	49,642	46
Oswego	10	10	20	120,146	45
Orleans	7	17	24	41,582	44
Oneida	10	17	27	232,500	43
Delaware	4	11	15	46,053	42
Cortland	11	11	22	48,494	41
Jefferson	4	12	16	117,635	40
Chenango	5	10	15	48,844	39
Washington	5	23	28	62,230	38
Essex	6	15	21	38,478	37
Tioga	7	10	17	49,453	36
Albany	20	18	38	309,381	35
Onondaga	21	16	37	468,463	34
Monroe	25	15	40	749,600	33
Rensselaer	7	19	26	160,266	32
Steuben	7	13	20	97,631	31
Clinton	11	23	34	81,251	30

continued ➜

TABLE 6. NYSDOH Grant Awards to Counties Ranked by Health Outcome *(continued)*

COUNTY NAME	SINGLE COUNTY GRANTS	MULTICOUNTY GRANTS	ALL GRANTS	POPULATION	HEALTH OUTCOME RANK
Columbia	6	19	25	61,509	29
Herkimer	5	10	15	63,100	28
Genesee	6	13	19	58,937	27
Richmond	6	15	21	474,558	26
Seneca	6	14	20	34,833	25
Cayuga	12	12	24	78,288	24
Orange	15	13	28	377,647	23
Lewis	6	10	16	26,957	22
Wayne	5	13	18	91,446	21
Schoharie	6	10	16	31,330	20
Otsego	4	11	15	60,636	19
Schuyler	4	14	18	18,186	18
Queens	4	46	50	2,339,150	17
Ulster	8	13	21	180,143	16
Yates	5	11	16	25,048	15
Warren	5	8	13	64,688	14
Ontario	4	15	19	109,561	13
Livingston	8	14	22	64,717	12
New York	23	83	106	1,644,518	11
Dutchess	12	16	28	295,754	10
Suffolk	14	17	31	1,501,587	9
Wyoming	8	16	24	41,013	8
Tompkins	8	11	19	104,926	7
Madison	6	11	17	71,849	6
Westchester	23	15	38	976,396	5
Putnam	7	9	16	99,042	4
Rockland	13	11	24	326,037	3
Nassau	20	20	40	1,361,350	2
Saratoga	6	16	22	226,249	1

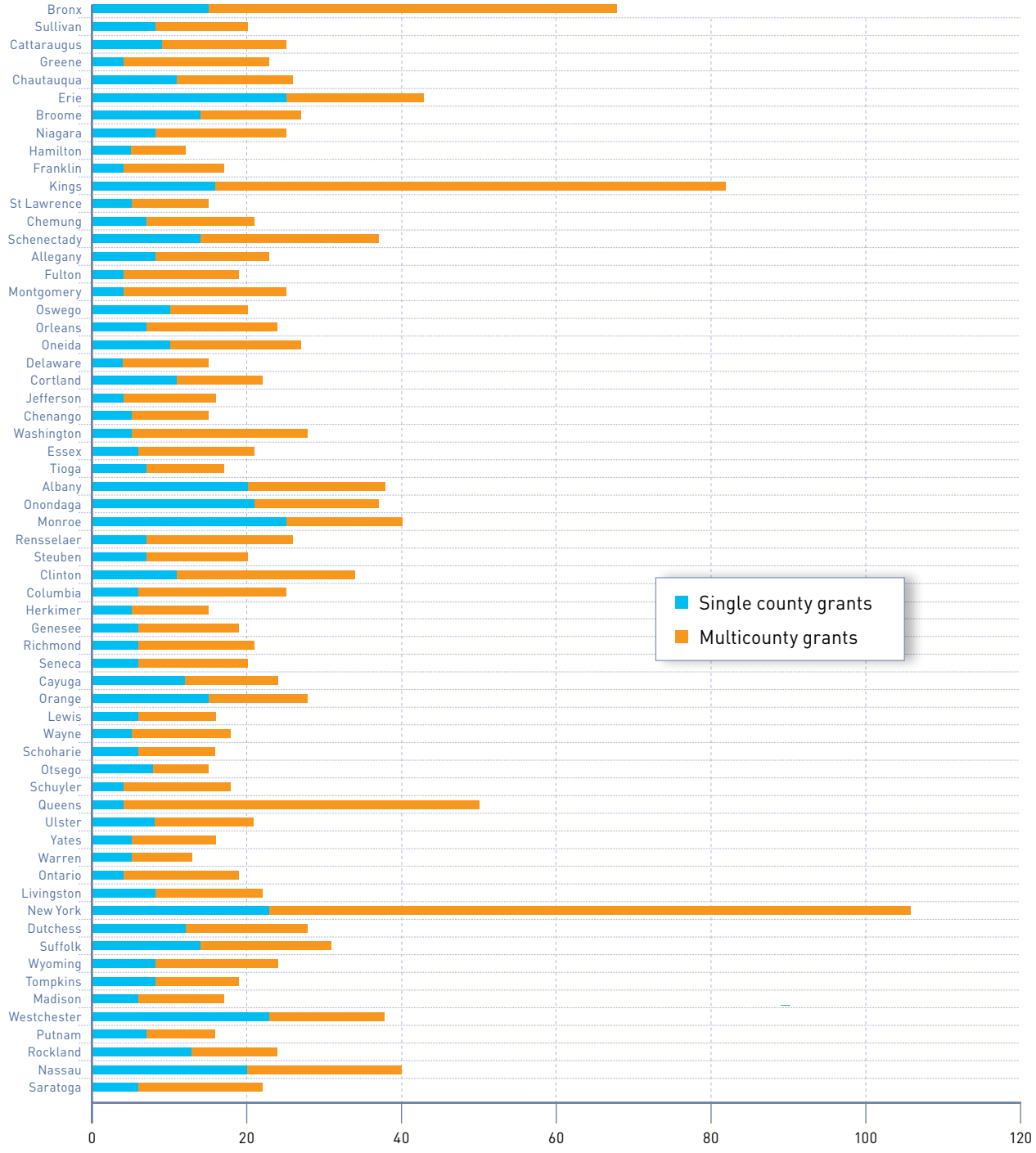
Sources: Population from United States Census Bureau, 2015.

Health Outcome Rank from the University of Wisconsin, 2016.

Note: Count of all grants to a county includes both single county grant awards and multicounty awards involving that county.

FIGURE 5

Number of NYSDOH Public Health-Related Grant Awards to Counties
(with Grant Year Including SFY 2015-16)



Grant Awards by Recipient Type

Recipient types were not provided as part of the grant data set. But through manual coding and review, 1 of 9 entity types were assigned to 921 of the 1,566 grant awards. These 921 accounted for 59% of the grant awards and 69% of the grant dollars. These nine entity types are counties, hospitals, federally qualified health centers (FQHCs), New York City-related entities (Fund for Public Health and Public Health Solutions), the New York City Department of Health and Mental Hygiene (DOHMH), rural health networks (RHNs), population health improvement programs (PHIPs), Boards of Cooperative Educational Services (BOCES), and universities and SUNY (entities were assigned to SUNY even if they also qualified as a hospital or university). The remaining 645 grants within the entity type of "community organizations and other unassigned" can generally be characterized as community-based organizations, such as community gardens, AIDS coalitions, family planning, disease advocacy groups, and rape crisis and anti-violence groups.

Although counties received the most grants (462 awards), they garnered only 18.7% of the funding. Except for the DOHMH, local health department Article 6 grants are included in the county entity type category. Meanwhile, hospitals secured 227 grants, which accounted for 22% of the total grant funds. The DOHMH and New York City entities have 23 awards (1 for its Article 6 local health department funding and 22 others), accounting for 19.3% of grant spending. RHNs and PHIPs, although important in their roles as community integrators, are minimal in their funding level at 1.2% and 1%, respectively; however, per key informant interviews described in the next section, their impact as community integrators may be greater than expected given the grant dollars spent, as shown in Table 7.

TABLE 7. 2015–16 Public Health-Related Grant Awards by Entity Type

ENTITY TYPE	# GRANT AWARDS	FUNDING TOTAL	% OF TOTAL
Counties	462	$156,415,239	18.7%
Hospitals	227	$184,693,740	22.0%
FQHCs	96	$44,440,636	5.3%
New York City Department of Health and Mental Hygiene and City Entities*	23	$162,113,318	19.3%
Rural Health Networks	38	$10,022,471	1.2%
PHIPs	12	$8,578,692	1.0%
SUNY	26	$7,101,441	0.8%
University	16	$6,921,388	0.8%
BOCES	21	$1,190,094	0.1%
Subtotal for Assigned Entity	921	$581,477,019	69.4%
Community Organizations and Other Unassigned	645	$256,964,901	30.6%
Total	**1566**	**$838,441,920**	**100.0%**

* City Entities include Public Health Solutions and the Fund for Public Health in New York City.

Key Informant Interviews

Thirteen in-depth, qualitative interviews were conducted with thought leaders across the State between July and December 2016. Respondents included leaders from local health departments, RHNs, community collaboratives, private foundations, hospitals, government agencies, and policy organizations (see Appendix 2 for a list). The interviews sought out the perspectives of key stakeholders and identified opportunities to improve the way New York State leverages its existing population health investments. A four-question interview guide was used to ask respondents about their:

- Background (current and prior);
- Involvement with New York State population health initiatives and funding;
- Current activities to coordinate population health efforts at a local, regional, or State level; and
- Recommendations to maximize the value that New York State receives for its population health funding.

Respondents were contacted via e-mail with a request for an interview. Background information, including a project summary and the interview questions, were sent prior to each interview. Interviews were approximately 45 to 75 minutes in length.

Analysis of interview responses began upon completion of the first six interviews and was ongoing throughout the data collection to develop themes. The analysis was inductive in nature and organized using the interview questions as a framework. Themes were developed by making comparisons across responses as the interview data set grew.

KEY INFORMANT INTERVIEW THEMES

Respondents provided a nuanced description of community experiences with population health funding and implementation in New York State. Overall, they found much to be proud of in their own community efforts and in the State's support of the Prevention Agenda. Many—but not all—communities have self-organized to support population health and been able to leverage one of several State funding streams to bolster their community-level effort. Local health departments,

PHIPs, DSRIP's Performing Provider Systems (PPSs), and RHNs were all mentioned as community backbone organizations or efforts that support local population health improvement.

This report and its interviews focused on identifying opportunities for improvement—as such, the constructive feedback should not be viewed as a reproof of the State's approach. Rather, this feedback should be seen as identifying opportunities to maximize the State's existing approach, namely, the substantial funding that New York State puts to work in supporting population health and the Prevention Agenda.

Enhancing Grant Program Design

It is widely recognized that the NYSDOH supervises a large portfolio of population health and other grants. Respondents recommended that local organizations that may already undertake relevant work within their communities can be leveraged to provide invaluable input to NYSDOH's grant program design. One respondent noted that before initiating a Request for Proposals (RFP) process, the State should vet the concepts with communities targeted for the grant. There is a recognition, however, of two barriers to community input. First, procurement laws may prohibit State officials from communicating about a grant opportunity once drafting of the opportunity is active. Second, federal funding streams—which account for nearly 60% of Prevention Agenda-related grant spending—may have specific constraints and requirements that NYSDOH cannot alter.

Respondents touted the Linking Interventions for Total (LIFT) Population Health grant as an example of NYSDOH proactively and successfully involving local organizations to provide input to a grant's program design. Respondents noted that NYSDOH made an effort to solicit community input prior to developing the grant RFP, and that the project offered important opportunities for local organizations to customize the work to their priorities and capabilities.

The PHIP program was identified as a missed opportunity to solicit community input. Six months into the three-year grant award period, NYSDOH was forced to cut 50% from the PHIP budget because the program was deemed not eligible for federal matching funds. The nascent

> "I would have suggested that the State step back and think about how the remaining PHIP funds should be redistributed." ***–Interview Respondent***

PHIPs were asked to achieve a 50% reduction in spending while making only minor adjustments to their scope. Respondents suggested that NYSDOH should have instead taken the opportunity to allow the PHIPs to fully repropose their project scope and deliverables to fit with the grant dollars available. This reset could have helped the PHIPs focus their scarce resources and maintain the credibility of their efforts within the community.

Community Partnerships and Community Integrators

Many respondents identified integrator organizations in their communities. These organizations take a variety of forms, including PHIPs, RHNs, and PPSs. Local health departments are often key participants and leaders in the integrator organizations. In some areas, the PPSs were seen as being important for developing collaborative efforts that brought together community-based agencies and allied health providers. Although some PPSs garner mixed reviews on their convening and community integrator roles, some respondents did want to see communities organize to maintain the PPS structure after DSRIP expires.

Several respondents identified DSRIP's Pay for Reporting (P4R) measures as a missed opportunity. As part of DSRIP, PPSs can select and commit to projects that fall under various domains, including Domain 4 (population-wide projects based on the Prevention Agenda). Under Domain 4, PPSs are asked to undertake a project related to population health and the Prevention Agenda that is driven by the findings of PPSs' community needs assessment. This alignment between DSRIP and the Prevention Agenda is viewed positively, but several respondents identified the reliance on Domain 4's P4R measures as an issue. Although there are 47 possible P4R measures associated with Domain 4, PPS payments are not subject to adjustment based upon the outcome of population health measures.[17] It has been noted that steady progress for population health improvements will primarily come through stronger remunerative or financial incentives, whereby material rewards accrue to individuals or organizations in exchange for acting in a particular way.[18]

[17] New York State Department of Health. Delivery System Reform Incentive Payment (DSRIP): Measure Specification and Reporting Manual, 2016. Available at: **https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/2016/docs/2016-02-25_measure_specific_rpting_manual.pdf**, accessed April 2017.

[18] Kindig, D.A., & Isham, G. Population Health Improvement: A Community Health Business Model That Engages Partners in All Sectors. *Frontiers of Health Services Management*, 2014, 30(4), 3–20.

Local health departments are viewed as critical collaborators and conveners, particularly for local community health assessments. But many respondents wished there were more flexible funding to enable local health departments to be more active participants in other community collaboratives, including PPS and PHIP activities. Most health departments face great challenges in fulfilling their core responsibilities with the limited resources that are available—and flexible funds tend to be scarce. As a result, health departments' level of engagement in collaborative initiatives can be constrained.[19] PHIPs were identified as being successful conveners in a couple of communities, but most respondents noted that the program is not seen as core to regional population health activities. Respondents cited the funding cut to the PHIPs as evidence of their precarious budget and political situation.

As noted above, these community integrators experience insecure or plateaued funding streams. New York State's waiver was recently extended from four to five years. The PHIPs are operating at 50% of their initial awarded funding level, and the RHNs' funding level has hovered between $6.5 million and $7 million since 2003 (2015–16 funding is $6.4 million) with no increase to account for inflation. Some respondents clearly articulated that "a stable backbone

> "The State needs to invest in its local Prevention Agenda coalitions."
> ***–Interview Respondent***

organization is needed to move a community forward," and community integrators "need the ability to plan forward and have a sense of stability." There was a uniform call for stable, secure funding streams and investment in local community integrator organizations. When funding streams are at risk, collaborators may step away from the table, and senior leaders from community organizations and local health departments may be recruited to more stable employment opportunities.

[19] National Academy of Medicine. A Perspective on Public–Private Collaboration in the Health Sector, 2015. Available at: https://nam.edu/a-perspective-on-public-private-collaboration-in-the-health-sector/, accessed April 2017.

Population Health Staffing at the NYSDOH

When asked about how their organizations and/or communities interact with NYSDOH on population health issues, many respondents stated that they have a contact or set of contacts that they go to with questions and key issues. Respondents noted that they can find help on issues related to grants management, evidence-based interventions for a specific population health issue, or even introductions to colleagues in other communities. The dedication and support of NYSDOH staff members were mentioned in interviews, and—despite being stretched thin—State staffers were identified as good subject matter resources.

The role of NYSDOH as an important resource, connector, and point of contact for stakeholders can be further amplified by having a visible senior-level champion for population health. Respondents identified that leadership from NYSDOH is essential and that access to a public-facing population health champion at NYSDOH could be instrumental in inspiring community leaders to envision their roles within the overall State strategy. Additionally, such an official could help facilitate greater coordination and streamlining of population health efforts among various State agencies and offices, as well as with federal officials.

Respondents also expressed a need for the Prevention Agenda to be more adequately resourced—namely, to have dedicated funds earmarked to support its implementation so as to ensure that it continues to serve as a strategic framework for total population health improvement. Several respondents noted that little or no additional funding or resources have been allocated by the State to support the operation of the Prevention Agenda. Respondents recognized that there is pressure to keep full-time equivalents and operating expenses low within the State, but they pointed out that a small investment in NYSDOH operations to support the Prevention Agenda may yield strong results in safeguarding the half a billion dollars of funding that the State distributes into communities to support total population health.

Findings and Recommendations

IOM MODEL FOR A MATURE POPULATION HEALTH PROGRAM

The National Academies of Sciences, Engineering, and Medicine (formerly the Institute of Medicine, or IOM), in a recent paper on population health's role in state innovation initiatives, outlined lessons learned from states—Michigan, Minnesota, Washington, Vermont, and Delaware—that moved early to incorporate population health. The IOM[20] identified the following eight factors that can influence and enhance the maturity of a state's approach to population health improvement:

1. Leadership and vision;
2. A broad definition of population health;
3. A health equity lens;
4. Degree of integration of clinical services, public health programs, and interventions targeted at upstream determinants of health;
5. Development of a community integrator infrastructure for population health improvement;
6. Degree of enabling infrastructure linking clinical and population health activities;
7. Effective community engagement and having the right partners, including payers; and
8. Degree of sustainability.

When these factors are compared with the findings from the key informant interviews and data analysis conducted for this report, New York State can be seen to have real areas of strength, as well as areas ripe for improvement as it seeks to enhance its State-level population health program, as shown in see Table 8.

[20] Institute of Medicine. Opportunity Knocks Again for Population Health: Round Two in State Innovation Models, 2015. Available at: **https://nam.edu/wp-content/uploads/2015/06/SIMsRound21.pdf**, accessed April 2017.

TABLE 8. IOM Attributes for Enhancing the Maturity of State-Level Population Health Programs and Key Informant Interview Findings

ATTRIBUTE*	ATTRIBUTE SUMMARY*	FINDINGS**
1. Leadership and vision	Leadership and vision needed at both state and local level to set the stage for improved results in population health.	• Leadership for population health efforts at the State level was identified as an opportunity for improvement. • Respondents suggested that capacity building and training are needed to develop and support local leaders. • Respondents were supportive of the State's Prevention Agenda and its vision for improvement.
2. A broad definition of population health	To achieve population health improvement, a geographic definition of population is needed. Initial efforts tend to focus on limited populations.	• The Prevention Agenda takes a broad geographic view of population health. • Existing NYSDOH grant funding does not often take a broad geographic view and tends to target limited populations defined by disease, demographics, payers, and other categories.
3. A health equity lens	State and communities encourage a "health in all policies" approach that will be foundational to achieving health equity.	• The Prevention Agenda has as one of its five overarching goals to improve health status in five priority areas and reduce racial, ethnic, socioeconomic, and other health disparities. • Anecdotal feedback identified health equity as a component of many State grants and some interviewees recommended a concerted health equity strategy.
4. Degree of integration of clinical services, public health programs, and interventions on determinants of health	Improving the health of a population requires the integration of clinical services, public health, and community-based initiatives targeted at determinants of health (e.g., built environment, secure housing, and availability of healthy food).	• Several community-level coalitions were identified as doing important work to integrate clinical, public health, and community programs to address social determinants. These coalitions varied by community and included local health departments, PHIPs, RHNs, and PPSs.
5. Development of a community integrator infrastructure for population health improvement	Mature population health improvement plans are integrated at multiple levels: practitioner, community, state/regional, and national. The most important is the community entity, backbone organization, or integrator.	• Community integrator organizations were identified in some communities and included PHIPs, local health departments, RHNs, and PPSs. • RHNs and PHIPs receive relatively minimal funding from grants, 1.2% and 1%, respectively, but their impact as community integrators may be greater than expected given the grant dollars spent. • PHIPs were identified as possible community integrators but only a small subset were viewed as achieving this role. • Respondents suggested stable base funding and technical assistance to community integrators.
6. Degree of enabling infrastructure linking clinical and population health	Mature population health plans have infrastructure that links clinical strategies to population health strategies.	• Two communities mentioned important collaboration involving their local regional health information organization and efforts to create linkages with data between clinical and population health interventions.

continued ➜

TABLE 8. IOM Attributes for Enhancing the Maturity of State-Level Population Health Programs and Key Informant Interview Findings *(continued)*

ATTRIBUTE*	ATTRIBUTE SUMMARY*	FINDINGS**
7. Effective community engagement and having the right partners, including payers	Community engagement is participation from the beginning and collaboration to determine shared goals. To achieve community transformation, an ongoing workgroup or coalition in which key decision makers are actively working together is critical.	• As noted above, community integrator organizations were identified in some communities and took a variety of forms, including PHIPs, RHNs, and PPSs. • In general, payers are not seen as active in these forums, but some respondents see DSRIP as setting the stage for important collaboration with payers. • Taking into account procurement laws and funder requirements, respondents nevertheless recommended that grant program design should include input from local organizations and communities.
8. Degree of sustainability	Grant support is important for testing programs and building infrastructure. Mature programs have sustainable financial models that reward improvements in population health.	• New York State uses a grant-driven model to test programs and build infrastructure. • Some respondents expressed a hope that value-based and total-cost-of-care models will support population health efforts long term.

*Source: Hester, J. A., Auerbach, J., Chang, D. I., Magnan, S. & Monroe J. Opportunity Knocks Again for Population Health: Round Two in State Innovation Models. Institute of Medicine, April 2015.

**Denotes responses from key informant interviews for this report.

RECOMMENDATIONS

This report's findings, the results of its data analysis, and the input of key stakeholders have informed the recommendations below. Feedback should be seen as identifying opportunities to gain more from the State's existing approach, namely, the substantial funding that New York State puts to work in supporting population health and the Prevention Agenda.

- **PROVIDE RESOURCES TO SUPPORT OPERATIONS OF THE PREVENTION AGENDA FRAMEWORK AND ITS INITIATIVES.** To effectively manage half a billion dollars, a core set of staff and operating resources should be dedicated to support the regular update of the Prevention Agenda framework and the engagement of stakeholders in its implementation. This minor investment of State operating resources will safeguard the substantial investment that New York State makes in population health grant programs and enable the State to gain better results through strategic management, engagement, stakeholder support, and assessment of outcomes.

- **DEVELOP, MAINTAIN, AND MAKE PUBLICLY AVAILABLE A POPULATION HEALTH GRANT DATA SET.** New York State should track its population health grants in one data set or information system and make these data available to the public. Development and maintenance of this grant-funding data set can serve as a critical tool for strategic management of the State's investment and achieve greater synergy and coordination across the various investments. A public list of Prevention Agenda contractors currently available on the NYSDOH website includes organization name, prevention area, and contact information.[21] This list should be expanded to include funding amounts, start and end dates, geographic area served (if more than one county), and a more detailed description of the prevention service. As it is a major source of funding, DSRIP Domain 4 public health projects should be included in this inventory. If made available as part of NYSDOH's open data initiative, this data set will also support communities' ability to coordinate and reduce duplication.

- **TAKE A COLLABORATIVE APPROACH TO THE DEVELOPMENT OF GRANT PROGRAMS.** Using the recent LIFT grant as an example of using a collaborative approach to program design, NYSDOH should gather input from regional stakeholders about program design as it develops new grant RFPs. Key questions for local stakeholders prior to grant design include: how do you imagine the goal we wish to accomplish and what support mechanisms would your community need to do this work? The LIFT grants can be used as a model to push communities to use evidence-based interventions while taking a community-defined approach to total population health.

- **CONSIDER A PHILANTHROPIC COLLABORATIVE TO SUPPORT NEW YORK STATE'S POPULATION HEALTH EFFORTS.** NYSDOH should consider an advisory workgroup of private foundations to offer input on program design, undertake collaborative policy analysis, and create opportunities to leverage public and private funds for population health. One state model is the Philanthropic Collaborative for a Healthy Georgia, a collaboration of 20 Georgia foundations and the Georgia Department of Community Health.[22] A nationwide model is the Convergence Partnership, which includes Ascension Health, the California Endowment, Kaiser Permanente, W.K. Kellogg Foundation, Kresge Foundation, MacArthur Foundation, Nemours

[21] New York State Department of Health. Public Health Contractors-Contact Information. Available at: https://www.health.ny.gov/prevention/prevention_agenda/2013-2017/contractor_map.htm, accessed April 2017.

[22] Minyard, K., Phillips, M., Baker, S. The Philanthropic Collaborative for a Healthy Georgia: Building a Public-Private Partnership with Pooled Funding. *The Foundation Review*, 2016, 8(1), 74–87.

Foundation, Rockefeller Foundation, the Robert Wood Johnson Foundation, and the Centers for Disease Control and Prevention.[23]

- **GIVEN THE CRITICAL ROLE THEY PLAY, INVEST IN COMMUNITY INTEGRATOR ORGANIZATIONS THROUGH SECURE FUNDING AND TECHNICAL ASSISTANCE.** Mature population health efforts benefit from a community entity to serve as a backbone or integrator.[24] New York State should make a concerted effort to provide sustained stable funding to community integrators, as they serve a critical community role in safeguarding the half-billion dollar investment that the State makes in Prevention Agenda-related activities. The spending for the current RHN and PHIP programs together only comprise 2.2% of prevention-related grant funding. Respondents noted that these minor investments in community integrators provide important structural support for the State's population health investments. The State should undertake a sustained multiyear effort to develop and support local capacity for population health leadership. Respondents envisioned a technical assistance program to help local communities implement evidence-based strategies and understand the larger vision and context of the State's Prevention Agenda and population health strategy.

> "Make available content experts for population health and community organizing. Some counties and regions lack perspective on where the population health improvement effort is going. They need to be connected with best practices and State and national efforts."***—Interview Respondent***

- **PROVIDE DEDICATED FUNDING FOR LOCAL HEALTH DEPARTMENTS TO PARTICIPATE IN LOCAL AND REGIONAL COLLABORATIVES.** Local health departments should be given dedicated funding under Article 6 or another source to enable them to allocate time for staff members to participate actively in community collaboratives. Because of their community health assessments, local health departments serve

[23] Convergence Partnership. Available at: **http://www.convergencepartnership.org/about-convergence/who-we-are**, accessed April 2017.

[24] Institute of Medicine. Opportunity Knocks Again for Population Health: Round Two in State Innovation Models, 2015. Available at: **https://nam.edu/wp-content/uploads/2015/06/SIMsRound21.pdf**, accessed April 2017.

as a critical connector to local Prevention Agenda priorities and often have an encyclopedic knowledge of community-based efforts related to population health. It is important to note that Article 6 funding cannot cover staff fringe benefits or indirect costs, and many counties find it difficult to manage these additional costs while staying below a 1% statutorily mandated property tax increase.

- **IDENTIFY A VISIBLE, PUBLIC-FACING SENIOR LEADERSHIP CHAMPION FOR POPULATION HEALTH WITHIN NYSDOH.** Stakeholders involved in population health need access to a public-facing champion for population health within State-level senior leadership. This official should have the authority to coordinate population health initiatives across State agencies and offices and have facility in brokering partnerships and blending science and community action.[25] This leader can help move New York's population health efforts by engaging with regions and articulating a vision and strategy for population health—inclusive of Prevention Agenda, DSRIP, SIM, and other initiatives—that regions can use as a framework for their own efforts.

[25] McGinnis, J. M., Williams-Russo, P., Knickman, J. R. The case for more active policy attention to health promotion. *Health Affairs*, 2002, 21(2), 78–93.

Conclusion

As a result of its funding and well-defined agenda, New York State is a national model in supporting population health. It ranks sixth-highest among states for public health funding and it appropriated half a billion dollars in SFY 2015–16 for community population health activities. Together with community stakeholders, NYSDOH has developed a clear set of population health priorities and measures as part of the Prevention Agenda.

This analysis sought to identify what funding New York State is providing and where it is going, how the State offers program support to population health grantees, and how its existing efforts can be organized to maximize their effect. An analysis of current funding streams and review of key informant input resulted in the following recommendations for New York State:

1. Provide more resources within NYSDOH to support the operation of the Prevention Agenda framework.
2. Develop, maintain, and make publicly available a population health grant data set.
3. Take a collaborative approach to grant design that further involves community stakeholders.
4. Engage private and community foundations. Consider formation of a philanthropic collaborative to support New York State's population health efforts.
5. Given the critical role they play, invest in community integrator organizations by providing secure base funding and more technical assistance.
6. Provide dedicated funding to increase local health departments' participation in local and regional collaboratives.
7. Identify a visible, public-facing senior leadership champion for population health within NYSDOH.

Much is working in New York State population health and may be envied by other states. But as the recommendations demonstrate, there are opportunities for further enhancements. The State should leverage its existing resources to develop a grant data set, identify a senior

population health champion, and collaborate with private foundations, as well as consider incremental investments to gain more return from its entire portfolio by supporting community integrators and local health departments and resourcing operation of the Prevention Agenda. These efforts will support New York State, its citizens, and community stakeholders, as well as help the State continue its positive progress toward achieving the goals set forth in its Prevention Agenda.

Appendix 1: 2015–16 Public Health Spending by the New York State Department of Health

PREVENTION AGENDA PRIORITY AREA	FOCUS AREA	APPROPRIATION TITLE	SOURCE	2015–16 ENACTED
Prevent HIV/STDs, Vaccine-Preventable Diseases, and Healthcare Associated Infections	Prevent HIV and STDs	AIDS Epidemic	State	$5,000,000
		Regional & Targeted HIV, STD and Hep C Services	State	$29,009,000
		HIV Health Care and Supportive Services	State	$32,056,000
		Hepatitis C Programs	State	$1,117,000
		HIV, STD and Hepatitis C Prevention	State	$31,080,000
		Public Health Campaign STD Component	State	$777,500
		Comprehensive HIV Prevention Project for Health Departments	Federal	$1,827,646
		Ryan White Part B	Private	$11,715,801
		STD AAPPS Federal Funding	Federal	$722,238
		New York State High Impact Care and Prevention Project (NYS HICAPP)	Federal	$92,004
	Immunization	Vaccine for Children	Federal	$103,000,000
		Immunization	State	$7,520,000
		Immunization Action Plan	Federal	$2,169,324
	Healthcare-Acquired Infections	Health Promotion Initiatives	State	$538,200
Prevent Chronic Diseases	Reduce Illness, Disability, and Death Related to Tobacco Use and Secondhand Smoke Exposure	Anti-Tobacco	State	$33,144,000
		Tobacco Enforcement	State	$2,174,600
		Tobacco Use Prevention and Control Program	Federal	$71,217
		NY TCP: Promoting Cessation and Quitline Services	Federal	$899,516
	Increase Access to High-Quality Chronic Disease Preventive Care and Management in Clinical and Community Settings	Hypertension Prevention	State	$631,700
		Hypertension	State	$232,300
		Childhood Asthma Coalitions	State	$1,163,300
		Children's Asthma	State	$213,400
		Asthma	Federal	$62,578
		Adelphi University Breast Cancer	State	$283,300
		Evidence-Based Cancer Services	State	$25,281,000
		Enhanced: Domain 4 - Diabetes	Federal	$86,288
		Diabetes Time to Treat Initiative (T3)	Private	$54,122
		Million Hearts State Learning Collaborative	Private	$283,903
		Capacity of Comprehensive Cancer Control Programs	Federal	$61,656
		National Breast & Cervical Cancer Early Detection Program	Federal	$2,628,092
		National Breast & Cervical Cancer Early Detection Program	Federal	$2,861,631
		National Comprehensive Cancer Control Program	Federal	$235,298
		New York State Arthritis Program	Federal	$208,030
		NYSDOH Colorectal Cancer Screening Integration Program	Federal	$924,395

continued ➜

Appendix 1: 2015–16 Public Health Spending by the New York State Department of Health Department of Health *(continued)*

PREVENTION AGENDA PRIORITY AREA	FOCUS AREA	APPROPRIATION TITLE	SOURCE	2015–16 ENACTED
Prevent Chronic Diseases *(continued)*	Increase Access to High-Quality Chronic Disease Preventive Care and Management in Clinical and Community Settings	NYSDOH Colorectal Cancer Screening Integration Program	Federal	$290,054
		National Comprehensive Cancer Control Program	Federal	$63,962
		Innovative Demonstration Project to Advance Population-Based Cancer Screening	Federal	$319,138
		Public Health Actions to Prevent Obesity, Diabetes, Heart Disease, and Stroke	Federal	$923,707
	Reduce Obesity in Children and Adults	Obesity and Diabetes	State	$7,463,300
		Sodium Reduction in Communities	Federal	$154,981
Promote Health Women, Infants, and Children	Maternal and Infant Health	Safe Motherhood Initiative	State	$34,700
		Maternal Mortality Services	State	$31,300
		Maternity and Early Childhood Foundation	State	$283,300
		Sudden Infant Death Syndrome	State	$18,400
		Universal Prenatal/Postpartum Home Visiting	State	$3,000,000
		Maternal Infant Early Childhood Home Visiting	Federal	$7,694,039
		Prenatal Care Assistance/Maternal and Infant Community Health Collaboratives	State	$2,296,400
		Supplemental Nutrition Assistance (SNAP)/WIC	State	$26,255,000
	Reproductive Health	Family Planning	State	$23,701,700
			Federal	$8,050,894
		Family Planning HIV	Federal	$660,000
		Cervical Cancer Vaccine / Family Planning	State	$4,700,000
		Adolescent Pregnancy Prevention (APPS)	State	$10,632,000
		Sexuality-Related Programs	State	$4,967,000
		Support for Expectant and Parenting Teens, Women, Fathers, and Their Families	Federal	$701,345
		Support for Expectant and Parenting Teens, Women, Fathers, and Their Families	Federal	$87,652
		Federal Maternal and Child Health Block Grant Account	State	$25,254,603
	Child Health	Fluoridation System (2 yr. appropriation)	State	$5,000,000
		Childhood Lead Poisoning Prevention	State	$9,891,300
		Lead Poisoning Prevention	State	$4,035,700
		Lead Prevention Program		$677,000
		School-Based Health Clinics /School-Based Health Center Providers	State	$7,932,000
		School-Based Health Centers (SBHC)	State	$10,400,000
		School-Based Health Centers (SBHC)	State	$826,354

continued ➜

Appendix 1: 2015–16 Public Health Spending by the New York State Department of Health Department of Health *(continued)*

PREVENTION AGENDA PRIORITY AREA	FOCUS AREA	APPROPRIATION TITLE	SOURCE	2015–16 ENACTED
Promote a Healthy and Safe Environment	Water Quality	Water Supply Protection	State	$5,017,000
	Violence and Occupational Health	Rape Crisis College Campuses	State	$4,500,000
		Rape Crisis	State	$1,000,000
		New York Rape Prevention and Education Program	Federal	$1,133,000
	Built Environment	Healthy Neighborhoods	State	$1,872,800
		Preventive Health Services Federal Block Grant Account	State	$4,350,200
Promote Mental Health/ Prevent Substance Abuse	Prevent Substance Abuse	Opioid Drug Addiction, Prevention, and Treatment	State	$450,000
		Opioid Overdose Prevention Program for Schools	State	$272,000
Public Health Capabilities	Policies and Regulation	Community Transformation Grant (CTG) - Small Communities	Federal	$888,107
		How New York State Public Health Laws Regulating Hospital Maternity Care Influence Breastfeeding	Private	$55,123
	Public Health Infrastructure	General Public Health Work	State	$190,800,000
		Genetic Screening	State	$609,000
		Sickle Cell	State	$213,400
		Tuberculosis	State	$565,600
		Public Health Campaign TB Component	State	$4,809,500
		Rabies / Zoonosis	State	$1,456,000
		Tick-Borne Disease	State	$69,400
	Preparedness and Response Activities	Public Health Emergencies	State	$40,000,000
	Population Health Improvement	Health Improvement Collaboratives	State	$6,750,000
		Planning Activities (Finger Lakes)	State	$1,250,000
		Rural Health Development Network	State	$6,400,000
	Workforce Development	Public Health Management Leaders of Tomorrow	State	$261,600
		New York State Oral Health Workforce Initiative	Federal	$172,640
	Health Equity	Study of Racial Disparities	State	$147,500
		Minority Male Wellness and Screening Program	State	$26,950
		Latino Health Outreach Initiative	State	$36,750
		Office of Minority Health	State	$266,000
		Indian Health	State	$22,500,000
	Social Determinants	Hunger Prevention and Nutrition Assistance Program	State	$34,547,000
		Child and Adult Care Food Account	Federal	$247,694,000
		Federal Food and Nutrition Services Account	Federal	$502,970,000

Appendix 2: Key Informant Interviews

Oscar Alleyne, M.P.H., Senior Advisor for Public Health Programs, National Association of County and City Health Officials

Sonia Angell, M.D., M.P.H., Deputy Commissioner of Prevention & Primary Care, New York City Department of Health and Mental Hygiene

Linda Beers, M.A., Public Health Director, Essex County Public Health

Courtney Burke, Senior Vice President and Chief Strategy Officer, Albany Medical Center

Trilby de Jung, Esq., CEO, Finger Lakes Health Systems Agency

Kerry Griffin, M.P.H., Deputy Director, Population Health and Health Reform, Center for Health Policy and Programs, New York Academy of Medicine

Indu Gupta, M.D., M.P.H., Commissioner, Onondaga County Health Department

Sherry Immediato, Director for Practice Integration & Development, ReThink Ventures, An Initiative of The Ripple Foundation

Ann F. Monroe, Past President, Health Foundation for Western and Central New York

Amanda Parsons, M.D., Vice President, Community & Population Health, Montefiore Medical Center

Sylvia Pirani, M.P.H., Director, Office of Public Health Practice, New York State Department of Health

Anthony Shih, M.D., M.P.H., Executive Vice President, New York Academy of Medicine

John Salo, M.P.H., Executive Director, Rural Health Network of South Central New York

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