
STATE OF NEW YORK

PUBLIC HEALTH AND HEALTH PLANNING COUNCIL

October 11, 2012

10:00 a.m.

90 Church Street

New York, New York

BEFORE: DR. WILLIAM STRECK, Chairman

MEMBERSHIP:

HOWARD S. BERLINER, SC.D.
JODUMUTT GANESH BHAT, M.D.
CHRISTOPHER C. BOOTH
JO IVEY BOUFFORD, M.D.
MICHAEL FASSLER
HOWARD FENSTERMAN
CARLA BOUTIN-FOSTER, M.D.
JEFFREY A. KRAUT
ELLEN GRANT, PH.D.
ANGEL ALFONSO GUTIERREZ, M.D.
VICTORIA G. HINES
ROBERT W. HURLBUT
ARTHUR A. LEVIN, MPH
GLENN MARTIN, M.D.
JOHN M. PALMER, PH.D.
ELLEN L. RAUTENBERG, M.H.S.
SUSAN REGAN c/o COLLEEN FROST
PETER G. ROBINSON
JOHN RUGGE, M.D., MPP
THEODORE STRANGE, M.D.

MEMBERSHIP: (Continued)

ANN MARIE THERESA SULLIVAN, M.D.
ANDERSON TORRES, PH.D., LCSW-R
PATSY YANG, DR.P.H.
DR. NIRAV SHAH, COMMISSIONER OF HEALTH

P R O C E E D I N G S

DR. STRECK: Good morning, everyone. I'm Dr. William Streck, Chair of the Public Health and Health Planning Council. I have the privilege of calling today's meeting to order.

I would note that we are webcasting. I would like to remind Council members, staff and the audience this meeting is subject to the Open Meeting Law broadcast over the internet. You may access the webcast at the Department of Health's website. They are available no letter than seven days after the meeting for a minimum of 30 days and a copy is returned.

As always, we just briefly remind ourselves of our ground rules. Since we have synchronized captioning it's important not to have multiple conversations at once. The first time you speak please state your name and briefly identify yourself. The microphones are hot. That means they pick up all sounds, rustling of papers and conversations that were not intended for the public. There's a record of appearance form that is outside the room. I remind the audience you should fill out that form. It's required by the Joint Commission on Public Ethics in accordance

with Executive Law Section 166.

I would like to give you a brief overview of today's meeting. Please note that in order to accommodate member schedules and maintain a quorum we have rearranged the agenda such that Project Review Recommendations and Establishment Actions will be the first item on the agenda today. That will be followed by the Professional Committee on Health Personnel and Interprofessional Relations Actions and Considerations, that will be an Executive Session. Following these, which we anticipate will take to lunch, we will return after lunch to the Department of Health's report at which time we'll hear from Dr. Shah who will provide a report on the Department of Health activities. Mr. Cook will give an update on the office of Health Systems Management Activity. Ms. Block will report on the activities of the Office of Health Information Technology Transformation. Next Dr. Birkhead will give a report on the activities of the Office of Public Health. Public Health Services will be addressed by Dr. Boufford, and under the category of Health Policy Dr. Rugge will summarize the 37 days of work that he has done

since our last meeting. Finally, Dr. Gutierrez will present regulations for emergency adoption.

I will remind the group, the Council members that conflicts and interest must be noted. So, if there are such that you have not made it known to staff please do so. When we do consider the Project Review and Establishment actions we do it in a batch process to facilitate efficiency, we will follow that protocol today.

And since that is the first item on the agenda, if there are no questions to this point I will convene by asking your adoption of the minutes of our last meeting.

Can I have a motion for adoption of the August 9th meeting.

DR. BERLINER: So moved.

DR. STRECK: Moved and seconded.

Is there a discussion?

Hearing none, those in favor "Aye."

(A chorus of "Ayes.")

DR. STRECK: Opposed?

Thank you.

We will now move to the Project Review recommendations. Prior to moving to that

deliberation, before you you have the proposed schedule for the Public Health and Health Planning Council, the 2013 timeline, and I would ask for a motion of adoption for this so that this can be promulgated and made available not only to us but the public at large.

DR. BERLINER: So moved.

DR. STRECK: Moved and seconded.

Any discussion.

Those in favor "Aye."

(A chorus of "Ayes.")

DR. STRECK: Opposed?

Thank you. So, that is the schedule.

We will now move to the Project Review Recommendations and Establishment Actions.

MR. KRAUT: Thank you Dr. Streck. It's my pleasure to provide the report of the Establishment and Project Review Committee held on September 20, 2012. Before I begin, I just want to have a special thank you to the staff of the metropolitan area office here that's headed by Celeste Johnson and her staff for being enormously accommodating to the Council. We had three overflow rooms. There was an enormous amount of

logistics in managing the space, the coordination, the AV to make sure the public had ample seating and was able to be heard. Without their assistance we could not have held that meeting and we deeply appreciate it and thank everybody that was involved and I want to recognize them for those efforts.

I'd like now to move Category 1, which is Applications for Recommendations for Approval where there were no issues or recusals, abstentions or interest. I'm going to move these as a batch.

Application 121204 C, NYU Hospital Center. Application 121431 C, Nyack Hospital. Application 121119 C, NYU Hospitals. Application 121468 C Montefiore Medical Center. Just a correction in that one that the extension clinic is going to be located on Waters Place. Application 121405 C, Hospice of Buffalo, an interested has been declared by Mr. Booth. Application 121363 C, Sunshine Children's Home and Rehabilitation Center. Application 121288 C, Living Resources Certified Home Health agency.

And I movie move these for approval with conditions and contingencies as indicated.

A VOICE: Second.

DR. STRECK: There has been a motion and A second for the approval as outlined by Mr. Kraut.

Is there a discussion on the motion?

Hearing none, those in favor "Aye."

(A chorus of "Ayes.")

DR. STRECK: Opposed?

Thank you.

The motion passes.

MR. KRAUT: I'm now going to move Category 2 Applications, which are recommended for approval that will include some recusals, but there's no dissent by the HSA and there was no dissent by the Establishment and Project Review Committee members.

The Application for Hospice Services, Application 121405 C, Hospice of Buffalo. Application 121084 C, Pine Haven Home. Application 121183 C, Wayne County Nursing Home. Application 121199 C, At Home, Inc., with an interest declared by Dr. Streck and Mr. Booth. I should also say that in the hospice application there was an interest declared by Mr. Booth, in the Pine Haven Home application an interest declared by Mr. Fassler, in the Wayne County Nursing Home an

interest declared by Mr. Booth and Mr. Fassler. Application 122122 C, Visiting Nurse Services in Westchester with an interest declared by Ms. Regan. Application 122123 C, Dominican Sisters Family Health Services, an interest declared by Ms. Regan. And I so move.

MR. FASSLER: Correction, I don't have an interest in Wayne.

MR. KRAUT: 121183 Mr. Fassler has not declare an interest on that application.

DR. BERLINER: Second.

DR. STRECK: There's a motion and a second for the Applications noted.

Any discussions? Is there further discussion on the motion.

Hearing none those in favor "Aye."

(A chorus of "Ayes.")

DR. STRECK: Opposed?

Thank you.

The motion passes.

MR. KRAUT: I now would call two Applications. 121225 C, Park Ridge at Home -- Park Ridge Nursing Home, and Application 121274 C, Finger Lakes Visiting Nurse Service. A recusal

declared by Mr. Booth, Ms. Hines an Mr. Robinson, all of whom are leaving the room, if they are here, and an interest in Park Ridge at Home, 121225 declared by Mr. Fassler. I so move.

A VOICE: Second.

DR. STRECK: Moved and seconded.

Discussion?

Hearing none, those in favor "Ayes."

(A chorus of "Ayes.")

DR. STRECK: Opposed?

Thank you.

MR. KRAUT: Would you please ask them to return.

I'm now going to call Category 3, Applications Recommended for Approval with the Following, there was no Public Health Council Member recusals, there was no dissent at the Establishment and Project Review Committee or contrary recommendations made by NHSA was available. This is an Application for a Certified Home Health Agency for Construction. It is the Home Aide Service of Eastern New York doing business as the Eddy Visiting Nurse Association, Rensselaer County, an interest was declared by Mr.

Fassler, to expand their CHHA into Schenectady County.

OHSM recommends approval with conditions, and the Establishment and Project Review Committee recommended approval with a condition with one member abstaining. So I so move.

DR. BERLINER: Second.

DR. STRECK: Moved and seconded.

Discussion?

Hearing none, those in favor "Aye."

(A chorus of "Ayes.")

DR. STRECK: Opposed?

Thank you.

MR. KRAUT: I'm now going to call Category 5 Applications that are recommended by disapproval by OHSM or the Establishment and Project Review Committee. This is Application 102376 C, Albany County Nursing Home. This is to construct a 200-bed replacement facility and certify a 30-slot adult day health care program. This project had been deferred by the Public Health and Health Planning Council at the December 2011 and April 2012 agendas. On April 5, 2012 the

Establishment and Project Review Committee requested the applicant reassess the cost of this project in light of the 2 percent real property tax cap legislation and submit an analysis of what the financial impact would the on the facility given the reimbursement system transition to a managed care reimbursement methodology.

OHSM recommended disapproval, the Establishment Project Review Committee concurred and recommended disapproval as well. And I so move.

A VOICE: So moved.

DR. STRECK: Moved and seconded for disapproval.

Is there a discussion on this recommendation?

Hearing none, those in favor of the motion "Aye."

(A chorus of "Ayes.")

DR. STRECK: Opposed?

Thank you.

MR. KRAUT: I'm going to hold off on a discussion of the Jewish Home Life Care of Manhattan until the end, we'll make that the last

project, just because we move the agenda to the Establishment, if other people from the public were going to attend I just want to give them the maximum amount of time to attend as long as the Committee is meeting. So, remind me to come back to this, but I doubt I'll need reminding.

I now am going to move to Applications for Establishment and Construction. I'm going to move Category 1 Applications which are recommended for approval where no issues, recusals, abstentions or interest were declared.

Application 121104 B, AMSC, LLC doing business as All Surge. Application 121403 B, Union Square. Application 121354 E, Hillside Polymedic Diagnostics and Treatment Center. Application 121355 E, A Maryland Operating, LLC doing business as the Mermaid Health Center. Application 122001 E, Beacon Christian Community Health Center. I'm going to read into the record on this that the submission of a photocopy of the Applicant's executed Certificate of Amendment of its Certificate of Incorporation acceptable to the Department will be added as a condition and contingency.

Application 121481 E, Haym Solomon Home for the Aging.

A Certificate of Incorporation for Betty's Be Brave Foundation.

A Home Health Agency Licensure. 2169 L, Greene County Public Health Nursing Home in Greene County.

We're recommending approval with contingencies and conditions as indicated. And for the Application AMSC and Union Square, we are recommending conditional contingent approval with an expiration of the Operating Certificate five years from the date of its issuance. And I so move.

DR. BERLINER: Second.

DR. STRECK: Moved and seconded.

Is a further discussion on the motion?

Hearing none, those in favor "Aye."

(A chorus of "Ayes.")

DR. STRECK: Opposed?

Thank you.

The motion passes.

MR. KRAUT: Now we move Category 2 Applications where we've had recusals but no

dissent by the Health Systems Agencies and no dissent by Establishment and Project Review.

I have Application 122004 E, Fletcher Allen Partners/Community Providers, Inc., an interest declared by Mr. Booth and a conflict declared by Dr. Rugge. I'm sorry. An interest declared by Dr. Rugge and Mr. Booth. This is to establish Fletcher Allen Partners, Inc. as the active parent of Community Providers and establish Fletcher Allen and Community Partners as the active parent of Champlain Valley Elizabeth Medical, Elizabethtown Community Hospital. Approvals recommended with contingencies and I so move.

DR. BERLINER: Second.

DR. STRECK: Moved and seconded.

Discussion?

Those in favor "Aye."

(A chorus of "Ayes.")

DR. STRECK: Opposed?

Thank you.

MR. KRAUT: Application 092058 B, HBL SNF, LLC doing business as the Rehabilitation and Care Institute of White Plains. A conflict has been declared by Mr. Fassler and Mr. Fensterman who

are both leaving the room. They have left the room.

This is to establish and construct a new 160-bed residential health care facility at 116-120 Church Street in White Plains known as the Rehabilitation and Care Institute in White Plains.

OHSM and the Committee recommends approval with conditions and contingencies, and I so move.

DR. BERLINER: Second.

DR. STRECK: Moved and second.

Discussion?

Hearing none, those in favor "Aye."

(A chorus of "Ayes.")

DR. STRECK: Opposed?

Thank you.

MR. KRAUT: Could we ask Mr. Fassler to return but keep Mr. Fensterman out. Mr. Fassler has returned.

Application 121427 E, JOPAL Sayville, LLC doing business as Petite Fleur Nursing Facility, to establish JOPAL Sayville, LLC as the new operator of Petite Fleur Nursing Facility. A conflict is declared by Mr. Fensterman who has left

the room.

OHSM and the Committee recommends approval with contingencies and I so move.

DR. BERLINER: Second.

DR. STRECK: Moved and seconded.

Discussion?

Hearing none, those in favor "Aye."

(A chorus of "Ayes.")

DR. STRECK: Opposed?

Thank you.

MR. KRAUT: Application 121407 E, 150 Riverside OP, LLC doing business as the Riverside, to establish 150 Riverside OPM LLC doing business as Riverside as the new operator of Kateri Resident, a conflict declared by Mr. Fensterman, who is out of the room.

OHSM and the Council recommend approval with conditions and contingencies, and I so move.

DR. BERLINER: Second.

DR. STRECK: Moved and seconded.

Those in favor "Aye."

(A chorus of "Ayes.")

DR. STRECK: Opposed?

Thank you.

MR. KRAUT: Could you ask Mr. Fensterman to please return.

I'll now call Application 121306 E, Hospitals Home Health Care, Inc., and interest declared by Mr. Booth.

OHSM and the Council recommend approval with contingency.

DR. BERLINER: Second.

DR. STRECK: Moved and seconded.

Discussion?

Hearing none, those in favor "Aye."

(A chorus of "Ayes.")

DR. STRECK: Opposed?

Thank you.

MR. KRAUT: Application 121358 E, Catholic Health Care System doing business as Archcare in Kings County. This is to establish Catholic Health Care System doing business as Archcare to become the sole corporate member of Empire State Home Care Service and Visiting Nurse. A conflict has been declared by Dr. Bhat and Mr. Fassler, who have both left the room.

I would like to note that a new exhibit was e-mailed and a copy is provided for you at your

table today.

OHSM and the Committee recommend approval with contingencies and I so move.

DR. BERLINER: Second.

DR. STRECK: Moved and seconded.

Discussion?

Hearing none, those in favor "Aye."

(A chorus of "Ayes.")

DR. STRECK: Opposed?

Thank you.

MR. KRAUT: Could we ask Dr. Bhat to return but keep Mr. Fassler out. Dr. Bhat has returned.

I'll call Application 122120 E, CenterLight Certified Home Health Agency. A conflict declared by Mr. Fassler. This is to establish CenterLight a not-for-profit CHHA to operate in Rockland County.

OHSM and the Committee recommend approval with a condition and a contingency and I so move.

DR. BERLINER: Second.

DR. STRECK: Moved and seconded.

Discussion?

Hearing none, those in favor "Aye."

(A chorus of "Ayes.")

DR. STRECK: Opposed?

Thank you.

MR. KRAUT: Can we ask Mr. Fassler to please return.

I'll now call Application 121318 E, Northern Lights Home Care. An interest declared by Mr. Booth.

OHSM and the Committee recommend approval with conditions and contingencies and I so move.

DR. BERLINER: Second.

DR. STRECK: Moved and seconded.

Discussion?

Hearing none, those in favor "Aye."

(A chorus of "Ayes.")

DR. STRECK: Opposed?

Thank you.

MR. KRAUT: Application 122121 E, Jewish Home Lifecare, Community Services. An interest declared by Mr. Fassler and Ms. Regan. To establish a CHHA to serve in Rockland County.

OHSM and the Committee recommend

approval with conditions and contingencies and I so move.

DR. BERLINER: Second.

DR. STRECK: Moved and seconded.

Discussion?

Hearing none, those in favor "Aye."

(A chorus of "Ayes.")

DR. STRECK: Opposed?

Thank you.

MS. REGAN: Did you say Rockland County? I think it says New York County.

MR. KRAUT: That's interesting, it's New York County but it says to establish in Rockland County because this was the upstate batch.

MS. REGAN: Oh, okay.

MR. KRAUT: So they had got an approval. Am I correct? Just I don't want to assert that.

A VOICE: Yes.

MR. KRAUT: I'm going to come back to the one where I'm in conflict. I'll do that last also.

I'm going to move now to Home Health Agency Licensures. Number 1991 L, International Home Care Services. An interest declared by

Ms. Regan. 1943 L, Omega Care and Health, Inc., doing business as Right at Home, interest declared by Ms. Regan. Application 2166 L, Tioga County Health Department, an interest declared by Mr. Booth. Application 1999 L Gotham Per Diem, Inc., interest declared by Ms. Regan.

OHSM and the Committee recommended approval with contingencies, and I so move.

DR. BERLINER: Second.

DR. STRECK: Moved and seconded.

Discussion?

Hearing none, those in favor "Aye."

(A chorus of "Ayes.")

DR. STRECK: Opposed?

Thank you.

This is a recommendation for Certificate of Amendment of the Certificate of Incorporation. North Shore University Hospital Stern Family Center for Extended Care and Rehabilitation. Mr. Fensterman has a recusal, Mr. Kraut has a recusal. The Project Review Committee recommended approval of the application. I so move.

DR. BERLINER: Second.

DR. STRECK: Moved and seconded.

Is there a discussion?

Those in favor of the motion "Aye."

(A chorus of "Ayes.")

DR. STRECK: Opposed?

Thank you.

Have Mr. Kraut return.

MR. KRAUT: I'm going to do Category 4. This is now Applications recommended approval with the following. We have recusals from the Public Health and Health Planning Council Members, Establishment and Project Review Committee there was dissent or there was a contrary recommendation by the HSA.

This is Application 121140 B, Endoscopy center of Niagara in Niagara County. An interest declared by Mr. Booth.

This is to establish and construct a single specially ambulatory surgery center specializing in gastroenterology procedures.

OHSM recommended conditional and contingent approval with an expiration of the Operating Certificate five years from the date of its issue was recommend and the Establishment Committee in affirming that there were two members

abstaining. So, I recommend conditional contingent approval, and I so move.

DR. BERLINER: Second.

DR. STRECK: Moved and seconded.

Is there a further discussion on this motion?

Hearing none, those in favor of the motion as presented "Aye."

(A chorus of "Ayes.")

DR. STRECK: Opposed?

Thank you.

MR. KRAUT: I'm now going to call Category 6, which were Applications for Individual Consideration and Discussion for Residential Health Care Facilities for Construction.

This is Application 121075 C, Jewish Home Lifecare of Manhattan, New York County, an interest declared by Mr. Fassler. The Application is to construct a replacement facility of 414-beds on a new site on 97th Street and permanent desertification of a 100 RHCF beds from the current compliment of 514. The proposed facility will provide a Green House Model of Care.

OHSM recommends approval with conditions

and contingencies, the Establishment and Project Review Committee concurred with approval with conditions and contingencies were recommended, but there was a significant lengthy discussion from the public and among Committee members, and so I so move approval.

DR. BERLINER: Second.

DR. STRECK: The motion is for approval and it has been seconded.

Is there a discussion on the motion?

DR. PALMER: I have a question. The mail that we received recently identified their particular view of the issues having to do with a violation of I guess federal regulations on this matter, is that something that we looked at and were satisfied with?

DR. STRECK: Mr. Cook.

MR. COOK: Yes. We did the review letter that came in from the advocates. There is no violation of either state or federal. So, we've approved it, we believe it meets all necessary requirements.

DR. STRECK: Are there additional comments on the motion?

Mr. Levin.

MR. LEVIN: One of the points that was brought up in some of the correspondence was some issues around the quality of the performance. I wonder if the Department has a perspective on that.

MR. COOK: I think from the context of this provider, this provider has a good record, it has been a provider when there have been problems they've worked with us. It is not one that we would identify of having any concerns going forward. That doesn't mean that there haven't been problems, there are problems in the best systems, but this is a credible quality provider.

MR. LEVIN: Thank you.

DR. STRECK: Is there further discussion on the motion?

DR. BOUFFORD: I just want to raise the concern that was raised, being a resident of that neighborhood but not exactly there, but the street that it's on and this issue of emergency evacuation and availability really and the kind of space involved in really servicing a 20- story building with multiple residents is really of considerable concern. That is the throughway to the West Side

Highway coming from the east side. You go across the park, you go right though 97th Street down to the West Side Highway, and it is always jammed all the time. So, I think something, some thought needs to be made.

I know I saw the photographic differences between the currents site on 106th Street which is really a double lane road, it's quite clear with lots of parking in addition there's a school there. So, I think this is not trivial because one of the fire safety issues that maybe internally these issues can be dealt with, but in the case of an evacuation of a high rise nursing home that in and of itself is of concern to me, but this is I wouldn't believe a serious problem if you know that neighborhood well. I don't know whether there's any conversation with zoning or people in the city, but that street is pretty much impassable at rush hour leaving the City and a lot of times during the day because it's a major thoroughfare from east to west.

DR. STRECK: Mr. Fensterman.

MR. FENSTERMAN: I think that this issue which was argued in the arguments that were

advanced and the letters that we're essentially advanced to the Establishment Committee and they were really repeated, and I appreciate the passion of which those who are advocating in opposition have taken their position. But on the issue of traffic, you know, I think they made it very clear that this project has passed all land use requirements from the city of New York, they have gone through the administrative process in the city of New York. And certainly in a land use context, zoning context, traffic is one of the major issues that are always considered. So, I think we're faced here with the problem that are we the correct forum for this issue to be addressed. And it was my view that if the New York City Zoning Administrative Agency passed and improved it, I don't know that there it was within our purview to attempt to override them or disagree with them in any way, and I felt that was a balance and that was really the issue here.

DR. STRECK: Are there additional comments from the members of the Council?

Hearing none then I would ask to vote on the resolution as presented for approval of the

Applicant and as seconded. So, those in favor of the motion please say "Aye."

(A chorus of "Ayes.")

DR. STRECK: Opposed?

Dr. Palmer is noted as opposed.

Are there others voting in opposition?

So the motion carries.

Thank you.

MR. KRAUT: I have one last Application. Application 121203 C, Personal Touch Home Aids of New York. This is an application to expand a CHHA and to provide services to Bronx, New York, Queens, Richmond, Nassau and Suffolk counties. The project had been referred from the last cycle so that full financial statements were provided to the Public Health and Health Planning Council members. Those documents were sent to us and the project came before the Establishment and Project Review Committee.

OHSM recommends approval with condition and a contingency and we so move, the Committee concurred and we so move.

DR. BERLINER: Second.

DR. STRECK: A motion and a second for

approval.

Discussion?

Hearing none, those in favor "Aye."

(A chorus of "Ayes.")

DR. STRECK: Opposed?

Thank you.

The motion passes.

MR. KRAUT: Just one thing. Ms. Johnson, at the beginning of the meeting I just thanked you and your staff for the extraordinary effort in helping the Council with its activities last week, two weeks ago when we had over three overflow rooms. We really did appreciate all your staff was so generous in helping to pitch in and helping and we just wanted to thank you and the staff and please let you know we appreciate it. Could not have had that meeting without you.

MS. JOHNSON: I will relay that. Thank you.

MR. KRAUT: That concludes the report of the Establishment and Project Review Committee.

DR. STRECK: Thank you, Mr. Kraut.

As you may recall when I introduced the meeting I said that we would move the second item

to our Professional Committee Evaluation which is the Report of the Committee on Health Personnel and Interprofessional Relation, that is an Executive Session of this group. So, I would ask that all non-council members and staff not involved in this effort to leave the room. There are, I believe, three cases for consideration today.

For those of you who wish to return there's adequate time to find coffee and get back comfortably, I would think.

(Executive session of the Professional Review Committee held under separate cover.)

DR. STRECK: We're ready to reconvene the meeting of the Public Health and Health Planning Council. We concluded an Executive session of the Professional Review Committee and we are now returning to the more conventional and public component of our agenda. We'll begin with a report by the Commissioner on the Department of Health activities.

Commissioner Shah.

COMMISSIONER SHAH: Thank you, Bill. Thank you all for joining us. I'll begin my report today updating you on several very promising

developments in the Medicaid arena.

First and foremost, as you know, the Department officially submitted its 1115 Medicaid Waiver Amendment to the CMS on August 6th and we've had continuing discussions around the Waiver. We made some real progress on the Mega Waiver and we are currently talking to them in detail about the other, the first Waiver, the DD Waiver while also continuing our conversations on the Mega Waiver.

Our hope is that this is an opportunity to really reinvest, and the keyword here is reinvest, $10 billion over the next five years to continue what we started collectively with Medicaid Redesign and the Governor's vision for a new health care system, a true health care system in the state of New York. Specifically, the savings projected are $34.3. That's a big deal. On top of that, that those savings generated are not on the backs of providers or patients or access or quality or safety.

And we have some really great success stories that I think -- if you haven't signed up for the MRT list, distribution list, you should. That is an opportunity. There is now newsletters

that go out every quarter or so talking about the programs and are progress on Medicaid Redesign. And we've been able to share some of the success stories that have already happened over the past year. I'll give you an example.

You know that access to Medicaid has improved and we have an additional 154,000 new members signed up. We're over the five million mark and we are going strong with the economy not going as strong yet. With the exchange we will add another 1.1 million people to the ensured roles of New York state.

I'll give you a great example of quality, it's also in the Medicaid newsletter that I referred to earlier. The Gold Stamp Program is an example where we come together with all the relevant stakeholders to really push down the rates of bedsores that are actually preventable. And the rate of bed sores have gone down one order of magnitude in the last year because of specific MRT reforms that promote the Gold Stamp Program and have improved outcomes for those vulnerable patients going between nursing homes and hospitals and ending up with bed sores. It's really a great

success story, a nice little piece. I'll refer you to the Medicaid Redesign team list server so that you can hear the whole story and see the statistics of the numbers. And there are many such success stories that we can talk about.

Big improvements in quality of care, big improvements in access and continued incredible savings in all. And the way I think of it is that quality and safety drive down the cost, and that's been really the model we've been championing. And it's not just us who believe that this, you know, sometimes we're in an echo chamber in Albany, we hear what we hear. The reality is it's getting outside of Albany, it's getting outside of New York state, it's getting to the national state what we have been doing and New York state has made a difference.

There was a recent New York Times editorial on the Medicaid Waiver. If you haven't seen it I encourage you to Google it. I'll read you a few exerts from that New York Times editorial. "New York state has substantially changed its Medicare program in the past year and a half and was likely to improve the health of its

poorest residents and rein in the program and its enormous cost. Most important for the long-term, the budget accelerates movement form uncoordinated fee for service care to managed care, from high price specialists to primary doctors, and from high cost institutions of care in a community through grants, technical support and financing for health information technology. CMS should allow New York to plow 10 billion of money the federal government will save if New York's projections of future Medicaid saving are insolvable as they look at first glance. New York could serve as a model to other states if it can show which reforms work, which don't and what their combined effects are on statewide spending."

So, this is a real success story and we are getting national press, rightly so, for what we've been doing together.

Bottom line, a Waiver is consistent with the CMS triple A, better care, better health and lower cost. And we are continuing to work with CMS very closely on a positive outcome for New York state on both Waivers.

We have been very engaged with all the

stakeholders and thank you to all of you. We received over 450 letters of support for the Waivers, which have been sent on to CMS. And as you know it's a work in progress. Keep it coming, keep the pressure on, keep the conversations going. My hope is that we would get something before the election, some word on it before the election, but at this point I'm not sure that the timing is going to work out exactly that way. But overall I'm still very positive on the net sum of what we requested.

One of the things that we've talked about in the Waiver which, again, I encourage all of you to read the 152-page document, a roadmap to the future, another blood work, is hospital acquired infections, and this is an example where we have a long ways to go in terms of quality improvement when sepsis rates range from 10 percent to 36 percent across our hospitals. That's something we really need to look at, the underlying sources of those variations and work hard to improve those rates.

To that end, the Department is holding a forum on sepsis on October 25th and it will be held

at, I believe at the New York Academy of Medicine. Thank you, Joe. This symposium will feature national experts and discuss proven strategies about how to affectively diagnose, treat and prevent sepsis, what their real impact is on families. And we will have a family recently affected and profiled in the New York Times who lost their 12-year-old son to sepsis as part of the forum. It is a chance for dialog. We've had a lot of different conversations going on around sepsis. We want to really bring them all together in one place and decide what we as a state, what we as hospital associations, what we as providers across the spectrum really need to do to focus on the number one cause of preventable death in hospitals today. So, October 25th. Please mark your calendars. It's all day at NYAM and more information will be forthcoming.

Another thing we talked about in the Waiver is our plan to implement mandatory Medicaid long-term care, and we had CMS approval of our plan from the MRT back on August 31st. This is really important as well. In addition to getting to care management for all in other areas, what this will

focus on is the dual eligible individuals over 21 years of age who receive more than 120 days of community base long-term case services, those folks will be required to enroll. And, moreover, dual eligible individuals between the ages of 18 and 21 as well as nursing home individuals will have the option to enroll in the managed long-term care program. It will allow for the continuity of care that has so often been lacking among dual eligibles as they move between different settings of care to make sure that they receive the best integration of community base long-term care services with the real system of care built around them that meets their needs.

This is going on in New York city. Enrollment will be going on followed by full implementation across the State early next year. And we're getting that approval from CMS. It's proof positive that New York's efforts to develop that comprehensive care management program is the right thing to do.

We will continue to have meetings with the public and stakeholders as we have in many other initiatives to provide education, outreach

and feedback to make this transition as seamless as possible. I know there's a lot of concern out there of what this will mean for patients. And our goal, as is everyone's goal, is to make this work for the patient, focusing on quality and safety, making sure that they continue to get all the services they need regardless of how it's structured in terms of payment. I think this is really a big deal and a really good thing.

Moving to the Health Benefit Exchange. We are working closely with the Department of Financial Services and other state agencies to make sure that what we stand up to is a success. The Affordable Care Act, as you know, ensures that health plans offered in state exchanges offer a comprehensive set of benefits and services known as the essential health benefits. These have to include from ten categories things like ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health and substance use, disorder services and so on. And following through a betting process we have decided in New York to select the state's largest small group plan, the largest small group

plan is the Oxford EPO, as the benchmark plan.

This plan provides the comprehensive benefits to consumers while minimizing cost to both individuals and small group markets. The Department submitted its decision on this benchmark plan to HHS last week. Our website, the Department of Health's website has a lot of information on what this plan offers, the betting process, and what we're thinking of how this will really help New Yorkers.

This has been all very good news, and yet we still face challenges. One of the big challenges in the health care system of New York is access to sufficient capital for all we need to do.

Last week the Department hosted a first of its kind forum that brought together national experts in the field of health care and finance to discuss the primary challenge, how to improve capital access for New York state health care providers. We were very lucky that one of our own, Dr. Rugge, was one of the moderators of this panel. And it's common knowledge that capital needs vastly outpace the current supply of capital. If we get this $10 billion Waiver, for example, that

represents, you know, 1 percent of New York state's health care spent over the next five years. So, 10 billion is a lot of money, and taken in the context of what the overall plan is, it's a drop in the bucket.

We know that there is a lot of interest and there is success in other states and other parts of the country accessing private capital, and this forum was an opportunity to begin the conversation of what makes sense for New York state. Last week was the first step.

I encourage those who haven't had a chance to -- who didn't make it to the forum to go on line to our web archive of the videos and view several of the forum discussions. There was a great discussion on the five things New York state needs to do in terms of changing its statutory environment to allow baby steps in this direction by Peter Millock. Navigant did a great overview of the state of the states and where we are and what our needs are and showing hot maps across the various regions relative to hot maps in Pennsylvania and other regions and what regional health care delivery systems have evolved to look

like relative to New York state exceptionalism.

We had presentations from Ascension and Vanguard and the Stewart Health System in Boston on what they've been able to achieve in short order with access to capital in thoughtful ways that allow them to preserve their mission while still advancing the finances to meet that mission. A good day of events and will be follow-up with other activities. Laura Levebvre of the Department really took the lead on that and will be following up with conversations with various stakeholder groups and just continue to advance the conversations. What does it mean? You know, we already have the for-profit system in the nursing home. How does that help or hurt? We already have the for-profit system in dialysis providers. How has that affected the landscape? So, these are conversations we need to have. What does it mean to be accountable in this environment? How can the broad mix of options really help us get there?

I want to switch to public health for a minute. As you know, there is a multistate outbreak of fungal meningitis. This has been big news across the country. Thankfully in New York

state we are working very closely with the folks who may have received some of these vials of steroids infected with fungus. Thankfully there have been no cases in New York state. So, we are working to make sure that all laws are upheld. This should not have happened in New York or elsewhere across the country and we're looking closely with the CDC to make sure that this doesn't happen again and that we do have the oversight in place to make sure such a disaster can be prevented in the future.

At the same time there's another meningitis in the news that has kind of been overshadowed. This meningitis does hit much closer to home in New York state and has also triggered a statewide response. And I'll tell you a story, you know, we have a student -- well, I'll get to that in a few minutes. I just want to remind everyone that these public health emergencies are a big part of the Department's job and because you don't hear of it doesn't mean nothing is happening. We are very vigilant. You will be hearing from our public health director later today about some of the details of what we've done in response to these

outbreaks.

I want to remind you about the flu shot. I got mine last week. It doesn't hurt. And if you're under 55 you can get it internasally now. My son was very happy to hear that. Flu is a real problem in New York and across the country. We have two new strains this year in the flu shot. It means it's more important than have to make sure you're up-to-date with your flu shot. Estimate of flu associated deaths in the U.S. range from a low of about 3,000 to about 49,000 people depending on how you count it, and thousands of New Yorkers are hospitalized every year with the flu. We've had 43 pediatrics deaths from influenza over the last four years in the state of New York. Obviously a key strategy is to get everyone to get the flu shot.

I am also suggesting that every health care delivery system in the state of New York work really hard to get their numbers of their staff vaccinated to over 90 percent. It's a sad state of affairs when New York hospitals across the state have rates of clinical staff vaccinations ranging from 11 percent to 93 percent. It's not acceptable. We have to work on this. It's about

culture change. In Iowa, the Hawkeye state, everyone there has over 90 percent. Rhode Island just passed a mandate. We need to get our act together when it comes to clinical staff having flu shots.

Turning to measles for a second. It doesn't mean that -- while measles is relatively uncommon, it's a disease that still circulates and it doesn't mean it can't be transmitted here. In fact, it can be brought to New York state from foreign countries by Americans who have traveled abroad. Just last month in an elementary school in upstate New York a student contracted measles while traveling abroad brought it back. And, thankfully, we were able with the work of the help of local public health really isolate that case and make sure that an epidemic didn't happen around folks who haven't had their measles vaccine. This is a concern as folks don't get their vaccinations that everyone agrees should happen. There have been some pushback against vaccinations. And it's important now more than ever before that we get the immunity, that we keep the rate of vaccinations up so that all of New Yorkers are protected.

In our new Office of Quality and Patient Safety we are working on things like flu shots and measle vaccinations. And, in fact, with nursing homes in our 2013 Nursing Home Quality Pool, we are going to encourage nursing homes to get their staff vaccinated for the flu. Nursing homes will be rewarded when they obtain the highest level of performance. And I'm a firm believer in driving positive change by incentivizing positive outcomes. To the extent that we can do that in other sectors across health care we will do that.

This was a big year for attracting mosquito-borne diseases in New York state including West Nile Virus and in turn acquired encephalitis. As of October 4th there have been nearly 1,000 positive mosquito pools for West Nile Virus, 79 human cases and five deaths. For Triple E the situation is more positive. There has been only one positive mosquito pool and the death of two horses. Fortunately, no human cases have been reported. And when we get the first frost we should be beyond that.

I want to acknowledge the tireless efforts that our Office of Public Health and local

health departments who work to raise local awareness for the risk of mosquito-borne diseases and how people could protect themselves. Our efforts began in May collaboratively and really worked full steam through the summer. You've seen lots of reports of West Nile nationally. The CDC reported last week that we've had the highest cases since 2003. And luckily while triple E hasn't been a problem in New York state it has been in other states. So, I'm pleased with the efforts of our strong state and local partnership that made this a relatively okay year for New York state.

On the primary care front, in late August the Department announced a latest round of the Doctors Across New York Grant to help meet the needs for underserved areas for qualified health care providers. In total during this grant cycle we've awarded $5.45 million awarded to 48 hospitals, health care facilities, medical practices and physicians for the recruitment and retention of physicians under the Doctors Across New York Physicians Practice Support and Physicians Loan Repayment Program.

As you know, these loan repayments can

be used to assist physicians in designated communities to establish joint practices in underserved areas or assist physicians practicing in rural or intercity areas with loan repayments. Each applicant was eligible to receive a grant of up to $100,000 for a two year period or $150,000 over a five year period for loan repayment. A really successful model for the Department and for the State as we're looking to continue this and expand it with our Medicaid Waiver.

I will conclude my report at this time and I'm open to any questions. Thank you.

DR. STRECK: Mr. Fassler.

MR. FASSLER: Commissioner, an update in terms of timeframe or reaction to it?

COMMISSIONER SHAH: Does anyone else want to comment on this?

MR. COOK: Vita demonstration.

MR. FASSLER: Vita demonstration.

COMMISSIONER SHAH: I think we have a report later on where we will address that.

DR. STRECK: Dr. Berliner.

DR. BERLINER: Commissioner, are you suggesting a voluntary approach to the

immunizations or are you suggesting that we take a more regulatory approach?

COMMISSIONER SHAH: You know, I am open to all suggestions. The reality is you can use soft power and you can use hard power. If you use soft power and you really engage your staff in patient centered approaches and flu shot being one of the primary ones, it's about patient safety, it's about quality of care, we cannot give our patients the flu in our facilities. That kind of an approach where you really engage your staff makes a much better long-term compliance, it helps change culture, and it extends beyond just flu shots to other areas of quality and safety. You can always do mandates. It's a last resort. It might be appropriate. I have no strong opinions right now. I would rather the soft approach because I think the benefits are much broader than a hard approach.

DR. STRECK: Mr. Fassler.

MR. FASSLER: Just a comment. Maybe it also would help to reach out to the Unions to get them on board too. They times will find resistance from employees who believe they'll get the flu from

the vaccine. Again, this is something where we can reach out to the major Union they can help us in that.

COMMISSIONER SHAH: I agree. I think this has to be something that the unions champion, frankly. I know that in Virginia they took a hard approach, they mandated it amongst their clinical staff, this is Washington state, and they had some issues with pushback. Ultimately prevailed. Within a year they had 92 percent compliance and within two years they had 98 compliance, a 100 percent compliance. And, frankly, if you don't want to get your flu shot, you can always wear a mask whenever you're in front of patients, that's always an option. So, you know, there's ways around it that still protect patients safety.

DR. STRECK: Mr. Kraut.

MR. KRAUT: You know, we always talk about what's in the purview of the Council and what's not in the purview of the Council. This is the kind of thing that, you know, we have taken up in the past, and when they did pass a mandate and then back off from that mandate for all the reasons we mentioned. You know, the real issue here is if

there is a role from maybe public health or from individual Council members, the provider community I think is stepping up and this year a lot of facilities are doing a very extensive communication and get voluntary compliance up. I think it would make a great statement if both the provider and the laborer were to come together and to figure out how to get those numbers up voluntarily. And an enormous issue in advancing public health would be if we were to come together and ask for a mandate. Recognizing there are a small number of people for a variety of reasons we all know that don't want to do this and there are going to be exceptions. It's very difficult to get a hundred percent of anything. But the symbolic significance of a mandate coming from the provider and laborer and the industry would be significant to the statement it would say and it would probably boost up that mandatory even if it was voluntary compliance, it would make an amazing thing. And maybe this is some issue we could take up or others could come here and advocate for.

COMMISSIONER SHAH: Thank you.

DR. PALMER: A more calmer approach, of

course, is necessary when we do get into this particular issue trying to get a hundred percent of health care professionals vaccinated because as you look at those communities where these professionals work, the lower your vaccination rate is amongst your staff the lower your vaccination rate is in those communities. So, there's a relationship if you take a close look, number one. You need a multiprong approach because if we did mandate a few years ago it worked very well until that mandate was held up in the court.

The other issue is cultural issue. If you go to Japan and see people who wear mask on their face to protect you in the subway. Here we wear mask on our face to protect ourselves. It's interesting that we have cultural differences that have to be addressed because we have a very diverse group of citizens as well as health professionals.

DR. STRECK: Dr. Martin.

DR. MARTIN: To that end, I understand maybe it's difficult to manage people getting a shot, but certainly less difficulty mandating that they wear a mask from December to March if they don't get a shot and they work in a health care

facility.

DR. STRECK: Just on that point, I'm curious about how we know whom has gotten the shots in that particular scenario? I mean, just the logistics of that because this is something that is being approached by some places. I mean do we have stamps on the cheek for those -- I'm just really curious.

A VOICE: It's on the ID.

MR. KRAUT: In our institution all of our managers get a weekly report as to who has received the shot or who has declined the shot. The only requirement was they either accept it or decline, and that's part of our program. And so, we actually know who has not. So, we would -- you know, certain places particularly -- and the logistics are not that difficult necessarily. We have 45,000 employees.

DR. STRECK: So, my question is really about the math. You don't decline, so then you have to have some identifier so that you don't have to wear a mask if you use that strategy. I was just curious about that.

MR. KRAUT: We haven't gotten to that

point yet.

DR. BHAT: I think what's interesting I think we have included this part of the last ten years or so starting mandates to the patient, 90 percent is what we need by and large I think you're right. As far as the staff is concerned I think it should be 100 percent but it's not. I think there's a lot of various factors of why someone would not want to. Unless we are going to say there's a mandate that everyone that is going to be coming in contact with a patient should have it. That's one of the things that we have not been able to do. As far as patients are concerned, I think it applies to more than 90 percent.

Coming to this weekend, I went to a social gathering where I will be injecting 30 to 35 people. I have been doing it for the last 20 years, the month of October I've been doing it. I think it's a good idea. The only thing is how we can make the staff, make the staff, the nurses and the patient recognition to say that they also should be vaccinated.

COMMISSIONER SHAH: You know, yesterday I offered to the entire academy that I would

personally vaccinate any of them. They were very excited and then I just pointed them across the street to the pharmacy where they can get it because I didn't actually have it on hand, but that's a good point. We have to start amongst ourselves on this Council getting vaccinated and lead by example and just tell them that getting a flu shot is not going to cause them to get sick. Everyone still, you know, there's a pervasive misconception out there. And I do believe that this is the right kind of contradiction that this body should engage in. I believe it is the purview of this.

DR. BHAT: If I had known about it I would have brought it.

DR. STRECK: Are there other comments or questions for the Commissioner?

Hearing none, Commissioner, thank you very much.

So, we'll now move to the Office of Health Systems Management report. I'll turn to Mr. Cook.

MR. COOK: Good morning. Thank you.

I just want to update the Committee on

Certified Home Health Agencies where we are. As you know, we left at where we probably have about a hundred or so or more than that applications that we are still have asked or given people an opportunity to submit additional information and are meeting with them either through conference calls or through actual meetings. We really encourage conference calls because you can imagine trying to schedule these discussions, but those are ongoing. There are going to be numerous ones that will not have the opportunity to have met with the Department by the 30 day deadline October 19th. So we are trying to let folks know that an extension is going to be granted, all they need to do is ask, and that it will have no detrimental impact on our evaluation of those applications. We are weaning through them as best we can. Whether or not we're going to be capable of bringing back the applications in the November, December framework is going to be very, very challenging, but we are trying to do the best we can and Becky and her staff have really been working very diligently to do that.

I want to talk a little bit about the

Certificate of Need and talk a little bit about the work of Dr. Rugge and Karen Lipson, but put a context in it and just so that we understand kind of where we stand and where we are.

I think it's important to look back over the last three years to understand the changes that we've made here. And not insignificant is the transition to one council. I know some of you don't remember those days, but I know Colleen and Lisa remember them very well, when we were trying to man two councils and coordinate the applications going through those councils. That was a challenge, and this body or many members of this body supported the mergers of the two councils. That has had a significant impact on efficiency, and particularly on staff efficiency.

Secondly, we moved to an electronic base/web base IT system that allows for all applications to be submitted electronically. And that has had a significant change in how we track applications, how we evaluate applications, how we interact with the public, not the least of which we save numerous trees. But that change, while it is not well-known to the public, offers an

unbelievable opportunity for even greater efficiency downs the road as we move into the second calendar event. And this Council is one that has strongly supported it or previous Council.

We raised the dollar threshold on CON to determine which ones need to go through a full Certificate of Need and which ones only needed administrative. As you may know now, any project under $15 million, unless it's specific to a service or adding of a service, can be done administratively. That has significantly reduced the types of projects that go through this Council. Legislation was signed that allows for normal repairs, one-to-one replacement of equipment in non-clinical projects not to go through CON at all, and that's probably going to take out anywhere from a 150 to 200 projects that would normally go through Certificate of Need.

We've developed an MOU with the Dormitory Authority that now is helping applicants to evaluate and to approve architectural drawings. That was one of our most significant backlogs that we had in the past with our architectural. The second issue that we've done is obviously began to

encourage and move to allow for self-certification with an audit function some protection for projects that are under $15 million.

But in looking at all of these changes, and they have been significant both in reducing the numbers that go through, but also in expediting the project, we haven't really looked at the basic tenant and the fundamentals of the criteria that, quite frankly, we evaluate in making decisions. And that's where Dr. Rugge and Karen have been focused on particularly over the last few meetings and the upcoming meeting relating to how should we look differently at issues like character and competence? How do we look differently at financial feasibility, if we should? How do we look differently and where should we apply need methodology? We're asking really core questions about the criteria that we will use to evaluate projects in bringing forth to this Council. And, quite frankly, they offer an opportunity just for very significant and radical changes, but just as importantly they offer opportunity to begin to link our reviews to resources into efficiency. And the work that's being done has been done already by Dr.

Rugge and by Karen. I really want to encourage you to spend some time looking at it. This is the first time probably in 20 years that there's been a fundamental review and evaluation of CON and what it should or should not be.

Part of the Committee discussions have really looked at perhaps we need to eliminate certain criteria, perhaps we need to add certain criteria. Like how do we include quality and quality metrics in our reviews? Can we use them effectively? Should we provide flexibility to integrated networks so that they can move services around those networks? One of the challenges there is how do we define the integrated networks and how do we look at those networks, and do we only look at networks on a regional network or if the network has upstate and downstate linkages, do we allow them to move services from downstate to upstate?

The point I want to try and encourage you is, this work right now is not necessarily strategic. A lot of the issues being discussed are very operational and they go to the heart of how we're going to make a recommendation to this Council on future projects. There is a lot of

reading. If you see Karen Lipson any morning at the tower you will see her hair that is less combed than it is today as you often walk into Karen's office and my office. But this is really an opportunity for this Council to participate in a significant form and put a stamp on critical issues.

I know that Dr. Boufford is looking at public health in this and community planning. How should that be included in the new changes to the Certificate of Need? So, we have before us a tremendous opportunity to not only improve how we do Certificate of Need, but maybe even more importantly to bring it up and be more reflective of the change in model of care that exist within the community and to recognize that with technology, whether it is the web basis or others, that the Department itself needs to be more efficient and more effective. And you, I believe, I'm retiring, need to challenge us from that contest.

I think once you get through this report and as we move, it is very important that all the debates and discussions that we've had relating to

quality, the heart of quality is how do you measure performance and how do you measure efficiency and how do you evaluate process that gets you to go. That debates need to happen once we agree on the changes so that Charley and Bob Smith and Chris Delker and whoever else is running the division, can begin to produce, I think, a report card that is presented on a monthly basis that tracks where we are each of the times. And as you know having been in the private industry, the first issue about any kind of report card is that everyone, one, will tell you the data is wrong and will tell you, number two, that the cases were more complex and, therefore, need more time. And we need to arrive at those measurements so that, quite frankly, we can show how effectively we're doing. I know Charley today is prepared to kind of discuss in a little bit more detail the changes that we've already began to recommend as part of the first round of those discussions.

But if I can leave you, and I would expect this will be my last report, I think it's incredibly important to read through all the material. Do not do it in the evening, it's not

possible to stay awake and do that. But we will only get to being strategic now if we really dig into the operations and the facts. And they are -- there's lots of minutia and there are a lot of complex issues, but this is the work that this Council, this will shape this Council in the next decade. And Karen and John have really done an extraordinary job, and Karen Westervelt has the absolute right view of how we can partake, but we really need your input. So, I'm going to leave it there.

I wanted to thank everyone. I will be at the December meeting. But this Council has always given me great kindness and I appreciate that very much. But more importantly I feel good about leaving because while I can't reveal the context, hearing Howard Fensterman talk about limiting the scope of the Council's work at the recent discussion gave me great pause, but nonetheless. So, thank you very much.

DR. STRECK: Charley, I assume you're going to follow with some comments here, but could I jus ask if there are questions for Rick before? Now, we are getting a lot of this information by

e-mail. Is the last round the best material to read, I guess would be more of a question to you? Is that the most updated for us as we aim toward closure? We're heading toward December, right, to get the report?

MS. LIPSON: The goal is to have adoption of recommendations by the end of December, I can't remember the date of the December meeting, early December. Before each meeting there's been a distribution of materials, and the materials generally relate to the particular meeting. So, I can't say that the last round of materials is the best one because the last round relates just to the public need topic. Prior to that materials were distributed that included stakeholder comments, and I would encourage everyone to read the stakeholder comments. We distributed a matrix with a summary of all the comments and then we distributed the full stakeholder comments. I think prior to the regional planning meeting we distributed materials about regional planning and some literature. And then at each meeting there was a power point presentation and I think those are all posted on the web now, I'm hoping that they are. So, those

might also be helpful if members have missed the Planning Committee meeting.

DR. STRECK: Other questions or comments?

Thank you, Rick.

Charley, you want to supplement Rick's remarks.

MR. ABEL: Sure. I just wanted to bring the Council up to date. Back in the June meeting the PHHPC presented the Department with a set of recommendations for Phase 1 of the CON reform efforts focusing on streamlining activities. And there were nine recommendations and 24 sub-recommendations that came out of that. Department staff has been actively involved in aggressively moving forward on each of those recommendations and sub-recommendations, imposing an implementation worksheet and gear toward target dates both through this, remainder of this fiscal year and next fiscal year for some of the recommendations.

Many of the recommendations require statutory change. Our expectation is that we'll be able to advance those statutory change as part of

the Article 7 budget bill and, therefore, many of the substantive changes, things like eliminating Certificate of Need applications for construction projects regardless of cost when there's no impact on capacity that has services, et cetera. You know, if we are able to be successful in moving that into the budget bill and clearly when the 2013/2014 budget we'll have statutory authority approved, we'll be able to implement and develop regulations to support those changes.

Now, some of the pieces we've already begun. In fact, today marks a milestone for changing the way we do limited life approval. Instead of limiting the establishment approval we're limiting the Operating Certificate and putting an end date, and in that manner the Commission and the Department has a responsibility and the authority to extend the review of those applications after a period of time and extend those limited life period of authorization into the future.

We've already implemented changes with respect to the PHHPC exhibit in terms of eliminating the architectural review but

incorporating some of those important elements into the project description. And we expect to be able to move forward with a more limited and focus set of certifications, set of services to be certified, noting a significant reduction from where we are today. We should be able to make that change effective with the beginning of 2013 and system changes to support ongoing registration efforts within a year from that. So, clearly we are well in advance on many of these efforts and it's our goal to be able to bring these changes through as efficiently as possible. Rather than going through each of the nine or 24 recommendations, you know, I'll take any questions if there are any.

DR. STRECK: Questions?

John.

DR. RUGGE: Just a few things. It only seem like 37 meetings, it was actually only three, although I think the trip to Rochester counts as three for four all by themselves. Karen Lipson has been amazing in her support, but also I would say that Rick Cook has been a major distributor as well as Karen Westervelt and Charley and Karen Madden and Chris Delker and Bob Smith have been a huge

team effort, and also. The Committee members who have been sticking with this and reviewing it very carefully. So, the credit goes to a very big group.

I am a bit concerned that the first time we'll have anything like a rounded report will be for consideration of adoption rather than having a preliminary draft unless one goes to the web or perhaps we'll be able to circulate early on some draft recommendations. I would opine that the sequence of meetings I think have been concealing around principle redesign. Which we will try to elaborate and draw Committee consensus tomorrow at our next full day meeting, and with that go directly into consideration of public need and access, which is really the heart of the matter in terms of how we reconsider the application of CON to changes in health care and the health care system.

So, it may not be necessary to read everything, but we will do our best to have some preliminary thoughts available to the Council before the December meeting.

Karen.

MS. LIPSON: I just wanted to clarify, the October 30th meeting I believe is scheduled for a review of draft recommendations. So, we may not have -- on October 30th, but a set of draft recommendations.

DR. STRECK: Other comments or questions?

Thank you.

We'll now move to the Office of Health Information Office of Information Technology Transformation. Ms. Block.

MS. BLOCK: Disregard the printed version you have in front of you and we'll have the full version up on our website and we'll provide full copies to everybody. Very briefly, I wanted to update the Council on a couple of things.

I have a made it my practice to give you updates on where we are in terms of Meaningful Use in New York state. At a very high level nationally, and the numbers go back to August because Medicare has a little bit of a lag in terms of their reporting. But you can see that a very significant amount of payments have now gone out the door, 6.9 billion in total. Medicaid and

Medicare interestingly pretty even in terms of the amount of funds which is great news for the Medicaid program, I think.

With regard to specific data on New York state, we're very exciting about this. You could see the Medicaid climbing toward the $200 million mark going out the door. Medicare a little bit ahead of that with 215. And with the total number of hospitals, and ETPs stands for eligible professionals, so that's primarily physicians and a couple other additional categories that were included in the law. As you can see that we're at at least $415 million that's gone out the door. So, this is getting to the point where I think we like to say this is real money, and I think it is really demonstrating a real benefit to the health care systems in New York.

I mentioned to John Rugge I happened to speak at a meeting in Plattsburgh last week to a regional group of the Medical Group Management Association which is typically the office managers. And I asked how many of their practices had attested for Meaningful Use and I would say about 80 percent of them raised their hand. So, I think

this is very encouraging in terms of the adoption.

The federal government has really been pushing to accelerate the progress on Meaningful Use and establish a program they're calling the Meaningful Use Acceleration Program and they'd like to really get additional providers enrolled in the system by the end of this calendar year. And so, being the overachievers that we are, we initially had a challenge level of about 6,000 eligible professionals, and we agreed to increase that to 9,000. And if you go back to the slide, two slides ago we're at least at about 7,200 now and the numbers are really growing quite rapidly. So we're quite confident that we will meet or exceed the challenge level that we set, and the Office of the National Coordinator has been very complimentary of New York state's efforts to do this.

Shifting gears. I just wanted to provide a couple of quick updates. I mentioned to the Council before that evaluation is an important component of our work, and through the HEAL program we have funded a number of rounds of evaluation. We have done that through a single source contract with something called the Health Information

Technology Evaluation Collaborative, a multi-institutional academic collaborative and you see the participants in that listed below.

This is just a quick overview of the different cycles of the HEAL program that have significantly targeted Health Information Technology and later on patient centered medical homes and care coordination efforts and 1017. This just gives you an idea of the sort of progression of activities of the HEAL program and the way in which the valuation strategy has addressed those.

There are three studies that I would like to quickly report on here that I think the Council would be interested in. So, one of the questions is have we had an impact in terms of DHR adoption by physicians. And what this study demonstrates is that we certainly have and we've gone from lagging pretty significantly from the national average to exceeding it. And if you look closely at the two light blue bars and the two darker blue you can also see that the rate of increase is significantly greater in New York state than it is at the national level. And we feel confident we can attribute that to the HEAL support

that we provide for HR adoption.

In addition, we are very interested in the extent to which we're actually improving quality as a result of electronic health record adoption and the advancing of patient centered medical homes. And a number of who are on health e-mailed newsletters I noted the other day a publication in the journal of General Internal Medicine this is based on looking at quality among primary care physicians in the Tatonic project and what was clearly documented was a significant increase in quality scores for those practices utilizing HRs and even better news of significant increase in quality for those practices who have gotten to the third level of patient centered medical homes. So, we're very closed with these results as well.

And one last one. They did a look at some of the data in Rochester and there are caveats associated with this that you can only look at as much data as you have for a particular study. But in general what they found was the that there were fewer patients admitted from the ED when they -- when ED physicians accessed information from the

virtual health records which is their community wide health records as compared to those which did not. And so --

COMMISSIONER SHAH: 30 percent difference.

MS. BLOCK: 30 percent difference, yes. Thank you.

So, we obviously need to dive deeper into what is actually behind that, but it is, obviously, a very significant finding.

One last thing that's not in this slide I'll just mention because it literally happened this morning while we were on the train coming down here. I think I mentioned in the past that the New York E Health Collaborative sphere-headed a national work group focusing on that really dreadful term EHRHIE interoperability.

If we go back to the HEAL 5 program when we first started our efforts to launch robust Health Information Exchange, we were ahead of the nation at that point. And what we ended up doing was having to convince all of these national electronic health record companies to adopt the New York specific standards as it related to Health

Information Exchange. And several of them were willing to do that because they had a pretty big market presence in New York, but a number of them were pretty bulky about the cost that they were undertaking to meet just one state's needs. And we managed to get there in terms of the integration effort, but it's fairly costly to customize the interfaces that are necessary to do this.

So, as NYSE was really sort of tallying up what the consequences of some of that were, they decided to convene all of these leading national vendors and the top states around the country, and what they managed to do was reach consensus on technical specifications that would be standardized in the EHRs, and they got 30 vendors, 30 national vendors to sign on the dotted line to agree to include a shiny ready version of electronic health records as part of their product offering. This press release was announced this morning with very positive comments from the Office of the National Coordinator acknowledging the significance of this. It also announces the fact that we have identified a testing body which will actually test each of these HRs to ensure that they in fact have

implemented specifications that the group agreed to.

So, this will be an enormous advance for New York because it will reduce the cost of future interfaces to participate in the statewide health information network for New York, but even more important it obviously will advance the cause of more efficient and more effective health information exchange nationwide, and we are very proud of the efforts of the New York City Health Collaborative to pull that together. That's my report.

DR. BOUTIN-FOSTER: I was just looking at the collaborators in the high tech, and where in this group of five are community physicians represented?

MS. BLOCK: Well, actually, there was one slide that I left out which, and I can send it to you, which reports on the variety of meetings, stakeholder consultations and things that they have done as a result. And there have been very active outreach to all levels of different professionals associations, community organizations and so forth. And then as you go through the step ladder case,

which is the following slide, you'll see that a number of these studies focus on a provider attitude. One of the studies we're going to be publishing is the sort of physician satisfaction with the use of EHR and Health Information Exchange and a variety of community base activities, and all of those involve direct involvement of the local stakeholders as well as statewide associations in the way that they went about doing that.

MR. KRAUT: I just want to congratulate you and your colleagues at NYSE, that that's an enormous -- I mean I don't know the technological, it's kind of like breaking the sound barriers, you know, technologically, because it create, as Rachel said, a pathway to remove a major obstacle and cost to interoperability to sharing the data and making it available.

And echoing back to the flu mandate issue. I'll bring up the issue maybe at this point, appropriately, is the requirement now to have participation of licensed Article 28 facilities in participating in interoperability through the REOs, and I'm wondering, I know you don't represent NYSE, but it would be useful maybe

to have the industry weigh in on whether it should be a mandatory at this point in time that we should mandate and hopefully we'll bring that back to the Council in whatever venue is deemed appropriate. But I think this is the time that we -- it's another step toward liberating patient information for the patients' use.

DR. STRECK: Mandating flu shot or medical records?

MR. KRAUT: I'll go with the information of patients should be moved with patients at their direction and not stay in institutional silos.

DR. STRECK: Dr. Grant.

DR. GRANT: Thank you, Rachel, for your report. Can you update us on what the level of electronic medical records use in the behavior health field, they're usually last in the train.

MS. BLOCK: We don't have New York state specific data on that, that will actually be added to a future survey that High Tech will be doing and in addition they will also be looking at long-term care adoption in one of their future surveys built into because HEAL 10 and particularly HEAL 17 we called out for participation of behavior health and

long-term care in those programs. So we'll have a little bit better survey data probably within a year. In addition though we do have some remaining HEAL dollars that we are hoping to target specifically to behavorial health and specifically to target needs for those providers who are participating in a Health Home Program. And to go back to Jeff's comment, we did include specific requirements as part of the Health Home Program to adopt and certify electronic health records and to participate in Health Information Exchange, but we phased it in recognizing that there might be resource challenges for some of those organizations to be able to meet those standards right away. So this is, again, a little bit of the idea of sort of a phased approach so that we can make resources available and we have the certified technology becoming available and we can work our way toward helping people to meet those requirements so that it is not an onerous process for them.

DR. GRANT: And you're moving toward, you know, implementation with the MRT, et cetera, that, you know, the horse doesn't come after the cart, et cetera. You know, are you parallel moving

in that direction.

MS. BLOCK: Absolutely. And we have identified additional resources in the Medicaid Waiver which would significantly enhance our efforts.

Also I should have reported we applied for the CMMI Grant and we included some resources in that. And that grant actually includes the Office of Mental Health, the Office of TWBD and OASIS and we targeted specific funding to support EHR implementation in all of their programs as part of that program. So, if we're successful with that grant we'll be able to also address those needs through that vehicle.

COMMISSIONER SHAH: It's funny that we can forget a $50 million grant we submitted. It just tells you the pace of what we're doing in the State. There are so many things going on. One of them, you know, under Commissioner Hogan's leadership they have been moving for their inpatient facilities to move to Vista, which is a really good thing, it's a big deal. So, to the extent that there are many folks championing this at many different levels, you know, the next maybe

in our correctional facilities for electronic health records there. So, we are actively thinking go about this and having these discussions not in our own silos but together around opportunity where there's a real dollars to make a difference.

DR. GRANT: Great. Thank you.

DR. STRECK: Rachel, can you comment on the variable development of the regional REOs and their interconnectivity or lack of same as faced in the state.

MS. BLOCK: Sure. So, right now we have 12 REOs operating across New York state, they are all operational, they are all significantly accelerating the pace at which they are including new participants in their networks. And also obviously consenting patients so that the patient information can be made available when a particular provider request access to that information. So, all of that is on a projectory along those line and it's pretty consistent across the state in terms of the pace of adoption. So, in general all of that is going in the right direction.

We are through the New York E Health Collaborative advancing a new model which offers

REOs the opportunity if they want to take advantage of it to share the technical platform that they're using for their Health Information Exchange. And we now have REOs from the southern through the Hudson Valley, almost all of the New York city REOs and the two on Long Island have agreed to participate in sharing that same technical platform. That has certain advantages, obviously, from a cost perspective. We believe that will be a more efficient way for them to get access to those services and may ultimately reduce the cost associated with participating in Health Information Exchange. But it also, obviously, makes it easier to facilitate the sharing of information across the boundaries of those REOs.

I think that we have an agreement in principle among all of the REOs to participate in statewide Health Information Exchange Across boundaries. But there are some governance and policy issues that we still need to sort though in order to get to the point where we have a fully interoperable system in New York. And our goal is to work through those issues through NYSE's Policy Committee and hopefully get to a consistent

agreement on a policy level at a minimum and hopefully extend the agreement on the use of a -- and technical platform as well by the end of this year.

COMMISSIONER SHAH: And the only thing I would add, is that the approach that we're taking is not a least common denominator approach. So, we're making sure that we're building on the innovation that various REOs have. When a particular REO is very advanced in identifying management and providing unique identifiers for every patient in the system or for every provider in their region, we learn from them, we build off of what they built rather than say let's start something new and let's bring everyone on board. It's been a real two-way conversation and it has to be and will continue to be to make sure that we leverage all of the great work that has gone on at the local level to bring it statewide.

DR. STRECK: It does sound to me like if you've assembled New York city, the southern tier and Long Island on a technical platform, that we're moving as a state in a direction that the other REOs are going to have to adapt to. Is that a fair

interpretation of what you said?

MS. BLOCK: You know, right now the way that the statewide health information network of New York is defined, is that each organization has adopted common policies and standards to facilitate interoperability. And, so interoperability can occur in the current environment. I think that it really boils down to a business decision that the upstate REOs need to get to, as well as for the New York E Health Collaborative, which is sponsoring this new common technical platform, to be able to show them what the performance levels, that they have it up and operating. They added many, many new organizations as a result of this downstate consolidation. So, I think it may be prudent to have a couple of phases and bring those factors. And the other thing is we need to then also take into account the additional time and expense of converting all of the interfaces that they built to the new platform, and that is something that we need to work out through NYSE to ensure that they have sufficient funding to be able to do that.

DR. STRECK: Jeff.

MR. KRAUT: Just to remind everybody,

you know, what Rachel is talking about is removing or overcoming the barriers to the technology of a single platform policies, procedure to facilitate the challenge for the local REOs and for all of us is using this technology in an appropriate way. That really is the issue. So, we may have in health X 7 million unique patient records in there, but we have less than -- we have a little less than 600,000 consents. So, you know, the issue -- and then you have a smaller number of users that are accessing those consent information. And that's a challenge every day is telling a good story of how this benefits the practice of good medicine. And I think that's -- it will move away from this issue because they really worked out a great model, I think. And it's now up to all of us to use this technology for all the reasons we discussed in all the committees at the table.

DR. RUGGE: A fundamental question, and that is, if we have a series of common policies statewide, as we should, and that we are would seem edging toward a common platform for other REOs, the fundamental question is, what is the rationale for having REOs as a separate entity rather than

regional offices of a single statewide on the Informational Exchange?

MS. BLOCK: So, if we go back to the construct that we initially created there is technology and there is governance. And we have always described the REOs as first and foremost providing governance for how the networks operate, as well as providing the technical services to enable that interoperable Health Information Exchange to occur.

That governance structure is associated with community leadership that is in most instances committed to developing a REO not just for the purpose of Health Information Exchange, but for the purpose of advancing the health care transformation, the public health improvement, other kinds of community related goals, and which I think would very nicely be able to leverage the kinds of things that we're talking about in terms of regional health planning, regional quality improvement initiatives and so forth.

So, one way to answer your question is, as we move down the road of the further consolidation of services and common policies, what

is the most effective governance structure then that would support that system over time. And I think that part of it is a question of scale. If we have a 100,000 physicians in New York state, there has to be either several or one entity that enters into the participation agreement with those 100,000 physicians. Someone who is accountable for ensuring that they can audit the access to that system which is required by federal law and part of our policies and procedures. So, there's a number of important privacy security and other data use agreements that are part of what the REOs job description is today. And it could be that we would determine that it would be both effective and efficient to consolidate that into a new statewide governance structure. But again, I don't think we're quite there yet. And we've heard loud and clear from some of the REOs, at least, that that direct connection to their local stakeholders is a very important part in their view of the sustainability of the of encouraging broader adoption and use of the network. That may not be a uniform preference across the State, but we've certainly heard it very strongly from some REOs.

DR. RUGGE: If I could follow-up. It would seem that much of what you described about promotion public health and system transformation connects directly to the regional health collaborative we're talking about for the purpose of planning. And careful thinking and living out, what are the connections or what are the overlap between what the REOs are now doing in their charge and that of those new entities. And for both those organizations I think there's a groping toward a business case, would the source of funding support these in a longer term. And one of the original purposes of the agreement, I think, was region by region there was a different strategy or a modulated strategy depending on the event of payers, the availability of major health providers or others to fund, so. Both of those are very dynamic processes. We're hardly about to close the chapter. What will REOs eventually come do be when they grow up.

MS. BLOCK: I'll just mention that NYSE has two very important committees that have recently convened, and their homework is to complete by the end of the year a version 3.0, if

you will, of what the SHINY is and what is our strategy for implementing it, and that address this question the role of the REOs, the technical services, et cetera. And then there's also a Sustainability Committee which is charged with coming up with a sustainability plan by the end of the year. And these were both deliverables that were included in NYCE's contract with the State. So we will have more to say about this by the end of the year.

DR. STRECK: Dr. Martin.

DR. MARTIN: Yes. I just I just want to remind people that -- when we think about REOs -- systems and hospital focus and the like, that still individual practitioners are part of the people using the REOs, and that Health Information Exchange means different things to different people. That a lot of what we, and, again, I remind you that I'm involved with the interborough REO, one of the -- REOs, is that a lot of our practitioners look for and when you see the patients also. It's not necessarily the Health Information Exchange that we focus on, that's not to say that it's not very important, but from a

patient point of view at ability to contact their doctors securely, to be able to change appointments, to be able to look things up and the like, on a more point-to-point sort of documentation thing is what people are looking for and certain physicians the ability to refer from one specialist from another, to get results back and to be able to begin to communicate is something that's of great import and is not necessarily focused on the Health Information Exchange in terms of exchanging large amounts of data, be able to look at in the emergency room and the like. So, I'm saying there's also different usages of the technical backbone. Some of them are obviously important for public health, some of them are more specifically for practice management and patient satisfaction and the like, all of these things that have overlapped. But they're not identical and different people in different areas have different needs. So, I think that this evolutionary approach of looking for commonality and where it makes sense to do it from a governance point of view may make a great deal of sense, but also to realize that a lot of it still is going to be somewhat locally

determined and there's going to be different use cases and different usages of this backbone can't be forgotten as we move forward.

DR. STRECK: Thank you for that discussion. Thank you, Rachel.

We'll move now to Dr. Birkhead.

MS. WESTERVELT: Dr. Streck, may I ask a question really quick.

DR. STRECK: Yes.

MS. WESTERVELT: Just in response to Mr. Fassler's question on a -- response from our OPHEC colleagues. So, the anticipated start date is January 1, 2013. CMS so far has been very positive. However, they're largely focused on implementation of managed long-term care, but so far to date it's positive.

MR. FASSLER: Thank you.

DR. STRECK: Office of Public Health activities, Dr. Birkhead.

DR. BIRKHEAD: Thank you very much. I'm going to update quickly on three items that the Commissioner mentioned in his remark.

COMMISSIONER SHAH: Gus, we can't see you. Can you move into the camera.

DR. BIRKHEAD: As I said, I am going to update on three of the disease outbreak intervention and really reiterate the point that these are examples of our public health infrastructure both state and local working sort of overtime if you've been following this in the news. The first is the fundal meningitis outbreak. This is related to contaminated lots of -- for spinal injections that was gave by the New England Compounding Center in Massachusetts. The staff -- at this moment is that there are a 137 cases and there have been 12 deaths in Penn State with over 13,000 people exposed to the three lots of contaminated -- presence alone. In New York I think we have been fortunate. We know that those three lots were distributed only to three different providers. Some of these were private physician offices doing spinal pain injections. One in Nassau County and one in Westchester and one in Monroe County. An public health workers from the State and local level have gone to work with those three practices essentially to notify all those 500 patients who received injections from these three lots in New York.

And fortunately at this point we have no indication of any illnesses. There have been a couple patients who have had possible symptoms related and have had repeat spinal taps, but we have not diagnosed meningitis in any of these patients.

This is a little unusual. Fungal contamination in spinal fluids, we're not sure exactly how long that may take to manifest systems, what the incubation period would be. So, I think we may not be out of the woods completely, so we're continuing to follow.

In addition, this compounding pharmacy has now withdrawn or recalled all lots of all medications the state has put out, and that involves an additional 50 or so practice or so in New York. There's no indication of contamination of those other medications or cases of illness related to them, but I think it's an example of sort of an abundance of caution in expanding this outward.

So, we're continuing to monitor for additional cases and just highlight, as Dr. Shah said, the regulatory environment around these

compounding pharmacies and in New York with the State Board of Pharmacies, the Department of Education really has a jurisdiction over the compounding pharmacy world and we've been talking with them and they are indeed following up to see what if any state laws in New York may have been broken in this case. So, more to come on that front.

We do -- this is a tremendous amount of work at our staff level. Staff basically have worked through the weekends on this and there are daily conference calls with DEC. It's interesting when you get one of these evolving national outbreaks that what you see is that on a daily basis the case definition changes, what we're asking to collect with clinical data changes. So, it's really a moving target. But I think an example of a pretty comprehensive response to what was a national problem. DEC has activated their emergency command center. They're running 24/7 on this and we at the state level practically are. I think those states that have a lot of cases are even more involved than we are. But we have been issuing alerts to our health care community through

our Health Alert Network in New York to keep them updated on this. So, that's the current status there.

This really I think superseded the news late last week about an issue with another kind of meningitis, meningococcal meningitis, the contagious form of meningitis. Interestingly HIV positive, men who have sex with men communities in New York city have -- to -- the state health department really, really did it, but over the past couple of years there has been a relative cost for meningococcal disease cases in this population I believe up to now 13 cases since August of 2010 of what is in the background population fairly greater.

I think what was particularly concerning was that in the month of September in the city there was one case each week. So it appears to be rapidly accelerating. And when you see meningococcal disease beginning to occur like this in a population it's an indication that you're having a high rate of carriage of the organism, it's a bacterial organism in that population. And with meningococcal disease fortunately there's a

vaccine that can be used, these are meningococcal and serum group C, so there is a vaccine available and what the city health department did and the state then extend to the rest of the state was a recommendation that HIV positive gay men who had recently engaged in sexual activity or other close contact with non-partners identified through websites on the internet or at parties in New York city be vaccinated.

As I say, I think the national news sort of overwhelmed the local news in hearing in New York about this and I think this week we're just beginning to deal with the issues. Vaccine is available and reimbursable through the health care system, Medicaid and our ADOP program which provides pharmaceuticals for HIV positive persons above Medicaid eligibility, both cover the vaccine and the vaccinations. And so we at the Health Department are both working with providers to get them promoting this and this sort of HIV positive men who have sex with men who may be at risk. So, more to come on that.

We've extended, as I said, the recommendation to the rest of the state HIV

positive gay men may travel to New York city for the purpose of being partners there. We have not seen any cases outside New York city but are surveillance is up and watching and we not, knock on wood, have another case in New York city either since this recommendation, but we recognize that we have not really made a big impact yet with vaccine. We have not had a large numbers vaccinated. And this is possibly a question we'll be able to get the message out and having a health care providers promote it and dealing with the reimbursement issues which are still a challenge even those these are, quote unquote, covered by Medicaid. The vaccine is fairly expensive on the order of a hundred dollars a dose. But that's the second.

And finally, just to update on the measle case that Dr. Shah mentioned. This case of a school child upstate occurred as a result of travel to Europe but this occurred in a school, this was an unvaccinated child attending a private school with a very high rate of religious exemption among its students. And so, as part of our public health measure to prevent further cases we actually had to exclude about 80 children from this school

who had not been vaccinated on religious grounds.

A number of those chose to get vaccinated, 37 actually received vaccinations so they could return to school. The remainder stayed out of school for a full 21 days incubation period. As Dr. Shah said, I think we were pretty fortunate that we did not see another case of measles. Measles have been extremely contagious and I think we must have been very lucky that this child was either monitored or not a full fledge contagious stage when they were in school or otherwise transmission was limited.

But this does highlight that we do even though that we have relatively high rates of measle coverage in the population and we have school requirements for measle vaccinations and basically have interrupted measle transmission in this country. We do have pockets of fairly high rates of exemption or lack of vaccination that are concerning and that in other states have less sustained measles transmission and even hospitalization -- outcome.

So, again, this is an area where public health is conducting surveillance measles and

reportable and we rapidly jump on every possible suspect case that comes to light, particularly so that we can practice outbreak prevention and control as have been in this case.

So, that's an update on sort of the unsum work of public health going on in the background all the time to protect the community. And I know Dr. Boufford is going to talk about the Ad Hoc Committee for the State Health Improvement Plan next. That committee, Ad Hoc Committee is beginning to work through to the conclusion of its work. We have a big committee day on October 31st. Going to spend a lot of time in trying to finalize the priorities or get closer to the final set of priorities through our five areas and then bring those to this Council at the December meeting. So, this will be another topic of discussion at the December meeting, a fairly extensive look at the State Health Improvement Plan and hopefully endorse and advise the Council at that time. So, I'll conclude there and take any questions.

DR. STRECK: Thank you, Gus, for that discussion.

Dr. Gutierrez.

DR. GUTIERREZ: More of a comment than a question. I'm concerned about simply saying Cortisone shots are associated with meningitis. Cortisone shots are used for multiple things. Specifically we are talking about the -- injections of compounded of steroid drugs. I'm concerned that private physicians are going to be getting a lot of calls. I got a Cortisone shot last week. That's not the issue here.

DR. BIRKHEAD: That's a good point. I think it's sort of identical that those kinds of questions will come back when something like this happens. I think we try to be clear in our communication. I will say that some of those preparations potentially could be used for joint injections and other kinds of steroid injections. So, we're on the lookout for potential joint infections, those would probably be less serious than meningitis, but these drugs could be used in other ways that may need lead to unusual or unexpected types of infections. But I agree, we also had the trouble of trying to explain this form of fungal meningitis is not contagious unlike the meningococcal that we're talking about. So, there

are mixed and many communications that are trying to get out here.

DR. STRECK: Mr. Levin.

MR. LEVIN: So this is probably more appropriate for the Commissioner than for Gus. Having been around the pharmacy compounding problem for a long time, remembering that we have a very unfriendly supreme court decision about commercial free speech actually related to this issue, but I'm still wondering, at the very least, whether the purchasing community, the folks, commissions, institutions that buy drugs understand the unregulated nature of pharmacy compounding. Not this regulation prevents bad things from happening in the regulations, this is a completely unregulated industry.

The right to compound by pharmacists was intended for pharmacists for example to take a drug and mold it into a different form of administration. If you can't swallow it they could make it into a suppository or liquid for another purpose. It was never intended to provide an end run around regulation of the making of pharmaceutical products. That's what it turned

into. The FDA and Congresses attempt to rein that in was aimed at advertising, which is the life, blood on the pharmacy compound, and that's what resulted in a supreme court decision that said no, you can't do that, this is a commercial. But at least an education effort to the provider and clinician community that there may be additional risk if you purchase products from this sort of supplier because they're totally unregulated by anyone.

COMMISSIONER SHAH: I think you bring up an important point. There are some regulations and some things that should not have happened and happened and probably broke the law in some ways. To the extent that this has been an end run around cost for many folks, it's suppose to be a local compounding issue for a given hospital or a system, you're allowed to do this, and that makes sense. But when you get national clearance like this you can see how it escalates very quickly and exponentially puts people at risk in our society. But the issues are real when you see cost differentials on the order of magnitude, actually have two orders of magnitude different for a

different compound that is sold by Pharma as a combined drug for a $1,000 an injection versus literally a dollar an injection, three orders of magnitude different for some reason. That has to bring up some other questions on what is going on here. As a society we need to look at that.

An article just came out today on how what we've done in Medicaid with our move to pharmacies and increase in generic has saved the state of New York over $400 million just this year, and that was just on the low hanging of fruit of moving the generic prescribing rate from 79 percent to 84 percent. That can save $400 million for the U.S. Medicaid program in a year. There's some issues that we should talk about more openly and this is one of them.

DR. STRECK: Are there other comments or questions for Dr. Birkhead?

Thank you, Gus.

We will now move to the Health Policy part of our meeting. John Rugge will talk about the or the continued discussion of the activities of the Committee on Health Planning.

DR. BOUFFORD: You skipped one. I was

going to lead off merging these two councils that on this -- but that used to be the Public Health Council, there's no audience, get a chance to present, the public health people would have to sit through CON to discuss that.

DR. STRECK: That was, I must say --

DR. BOUFFORD: I recognize by reversing the agenda we undermine that possibility today, but we also appreciate the opportunity.

DR. STRECK: In my defense for my egregious error here, I would point out that I was a big advocate of that, to give you time. And as Gus was speaking it occurred to me that often the work of public health their days in the sun is usually under a bright light of anxiety over the crisis that they are managing, so. It's nice to have this report. I had a clue about this report on the train this morning. So, please proceed.

DR. BOUFFORD: Thank you. I'll be brief.

Just to remind everyone, we started our process about a year ago with a review of the existing State Prevention Agenda and how well we did. And we tried to apply the learnings from that

to the design of this process over the last few months which has been highly inclusive. It was really kicked off with a multi-stakeholder so-called Ad Hoc Committee that was appointed by the Public Health Committee of this Council and includes business, professional organizations, regional perinatal networks, hospital associations and advocacy groups and others. And this group really took a look at what we accomplished over the last four years or so in the Prevention Agenda, the State, the State health status and then help them develop a set of principles that we wanted to use as well as goals for this work and identify five priority areas to develop the new agenda in prevention of communicable diseases, safe and healthy environments, women and infants and children health, prevention of substantive abuse and promotion of mental health and vaccine preventable diseases and HIV and STDs. So, those are the five groups.

They were each constituted a working group in June of this year. They have been working over the summer with the co-chairs of health department experts and private sector experts or

advocacy groups who have been meeting. They have all met in person at least once and virtually multiple times. A group size ranges from about 30 to 75 or 80, and there's statewide participation. It's really, really rewarding, I think, and exciting for everyone.

There's been a Steering Committee of the co-chairs of each of these working groups that's been meeting by phone every other week. And added to that Steering Committee are individuals, invited are individuals and sometimes participating from OHSM or Rachel's group, the Office of Mental Health OASIS, HANYs, CHICANYs, which is the community health center group, and community advocates for disabilities as well as the Council on Minority Health as well in the State and for general advocacy. So, it's been a venue where we really try to coordinate across the working groups and also make sure the commitments for cost-cutting for broad base engagement and attention to disability and other issues, I'm sorry, to disparities and disabilities has been attended to.

The group submitted their report on October 15th. They had to identify within the

frame of the problem they're tackling what objectives would they select and what would their goals be. This was a measure of what the major problems are, what are subject interventions, which is always an issue, effective interventions, where's the evidence, and then how would you measure that we made a difference. So, each of them have come up with three, four major objectives in that area. They're trying to get -- there's a standard boiler template that everybody used, a standard exercise of moving to the levels of intervention from the basic access to health care and preventative services to broader policy changes in the State, including the agriculture policy, transportation policy, housing policy. So, each of them will try to tackle things at each of these levels.

There was also a stakeholder map, so every group has to fill out who the players are that have to take action in some kind of aligned way to make a difference in making this happen. And then design interventions and metrics. And there's been absolutely spectacular support from Gus Birkhead and his team. Sylvia Pirani is like

the iron woman of public health. I don't know how she does it, frankly, but she is just incredible. And a really terrific team of professionals throughout the public health of the house working on this and collaboration across the Department. So, it's been very important.

We do have those reports will be available in draft for comment in this meeting that Gus eluded to on the 31st of October. The Ad Hoc Committee will be meeting for about five hours in multiple sites around the State just to sort of review how well everyone did in relation to their expectations and their comments and comments that are being solicited actively. On the website we try to set up models, the MRT process by having an interactive website. It will be brought to the Public Health Committee at a meeting we're working on and taking a page from our colleagues on the Planning Committee early November, separate Public Health Committee meeting to kind of work through this so we can present to the council on committee day, and then following a formal council meeting of December we'll have our work done.

As if that weren't enough, in parallel

the public health -- the Health Department has been putting out what we hope will be complimentary guidance for local health departments and for hospitals since they have the responsibility to do that. Our local health departments need to present a community health assessment and health improvement plan for over this two to three year period. Hospitals also have to submit their community service plan. So, we've been working very carefully to try to conform the guidance and integrate the guidance to both entities so that they will see the logic of collaborating on community health needs assessment and hopefully be able to use the State Health Improvement Plan at least to some degree working on the five priority areas in collaborative work at the local level. We expect that will be going out shortly. And this guidance also tries as much as possible to reflect the expectations of hospitals under the Accountable Care Act for community benefit planning. So, we're trying to watch all the moving parts at once.

We've also had an initial meeting on the process of roll-out at the local levels which will begin in January. We've been reengaging the Robert

Wood Johnson Foundation communication pro bono communication staff which they provided for us and other experts in community engagement. And this is where we really want to take the lessons learned from last time where we did not get, except in a very few places around the State were we able to get beyond picking an issue and planning into implementation and evaluation. So, we're very cognizant of that, trying to do what we can around communication and information sharing.

But I also wanted to just put in a plug as we're speaking about -- I know the potential is there in terms of the Waiver, but last time I believe there was some small amount of money found, relatively small considering the cost of delivering health care small, a large amount of money, about $7 million or so, that was made available for local implementation support. At this point in the time we have some residual. We're able to got a grant from the Robert Wood Johnson Foundation to support the staff work on these working groups. We have a little bit of that left which we're hoping to use as seed money in designing the implementation process. But there's some plan for trying to

secure other funds, but there are many possibilities of thinking about a strategy for local support that would provide some financial incentive, even just small seed money grants to local communities that really take on this multi-stakeholder engagement. I think we would hope that we could, you know, sort of bring that to your attention to see if that is a possibility, but everybody is working really hard and we also have plans. And we have also been working closely with John and appreciate Karen Lipson's support and John's openness to having us. And I also want to thank my Public Health Committee colleagues who have been beautifully coming to most of the Planning Committee meetings as well as their own meeting. So, everybody is working on it. Thank you.

DR. STRECK: Comments or questions for Dr. Boufford?

COMMISSIONER SHAH: So you're wrapping up your work pretty quickly. Have you thought about a Phase 2?

DR. BOUFFORD: Well, I mean Phase 2 is clearly a local roll-out, and that's the challenge

because the local health departments who are doing what Gus is talking about and, we all know are very thin on the ground, are going to be asked to, at the very least, take a convening role with hospitals. We're hoping -- we've had great participation from HANYs and Greater New York in all of our meetings and they've really been having presentations and others, I know staff have been presented to them. And we're hoping that they could kind of be anchor conveners for stakeholders around, especially in local communities because they really have to pick the issues that they think are most important. They'll have a strong database to help them do that and then figure out what strategies that are -- where the evidence is there, where they want to really coordinate their collaborations to really make a difference in our community and then measure that difference. And we didn't get that far last time except in certain selected areas. Obviously the Rochester Finger Lakes area is an exception, there were a few others. But we really want to move that along. So that is in a sense our Phase 2 is getting ready for that.

And then hopefully some of -- I think Rick highlighted something that's really important on the operational side of looking at the synergies of the MRT, the CON, the health planning and the State Health Improvement plan. There's also conceptual integration here, which I think is equally important and is challenging. I mean, the issue of community health need is more than an operational question. I mean, it's really saying if we have some things going on in local communities or in regions that are working -- that have a health agenda that's been agreed by state leadership that is suppose to be implemented, how does that connect to health planning, how does that connect to this potential element of the CON. And those are all happening in different, you know, sort of not stovepipes, we're all talking to each other, but under different mandates, let's say. And I think one of the real challenges within the group -- and within our work is that they will all come together in December, January, February, March, and it's a big challenge. So, it's operationally and conceptual integration, so.

DR. STRECK: You talked about the State

Health Plan and the Community Service Plan, the health department, I mean the county health department plan, do you see this kind of reaching some shared ground, bring in IRS guidelines in terms of community service in terms of reporting so that there would be at the county level, a provider level that we would have some format or approaches to getting some of this information together?

DR. BOUFFORD: Well, the draft guide as I've seen hasn't come out the other end of the pipeline yet, but the draft guidance was done very consciously to try to mirror community benefit requirements of IRS and connect them as closely as possible to the local health department obligations. So, hopefully that will be the case. I think then the challenge, I think, and, again, this Council could have a role there and Karen Westervelt has been participating in all these conversations, but I think the link with OHSM, the links with sort of the financing side gave some of the MRTs and others, I mean all the questions, can we bring the reporting that comes through also come through by tradition at least different spickets, can we bring that together to really understand at

the community level how things are going. And that will be important under the health planning agenda. So, we're doing the best we can at the front end. And then the issue will be can we really figure how to conform these things in the delivery side.

DR. STRECK: I like the spicket metaphor there.

Any other questions for Dr. Boufford?

We'll now move to the Health Policy discussion with Dr. Rugge and the continuation of the health planning comments from earlier.

DR. RUGGE: I think we've already more than eluded to the fourth mark which we're trying to do through CON redesign only to say that at least, again, try to formulate recommendations, we've tackled health planning first. Health planning having been the predecessor really work of CON. CON really was convened at the consequences and culmination and outcome of health planning going back to say how do we connect all this that Joan had talked about with a reasonable approach putting all these planning activities together with a test case perhaps being with distribution of funds through the Mega Waiver to emphasize

collaboration and emphasize forward looking to benefit entire communities. Having said that, we meet again tomorrow and we'll be considering the principles and redesign and rolling those into consideration of need.

There is one further business for this Committee, and that is on July 25th the Planning Committee voted to streamline the addition of ophthalmology and endoscopy for ambulatory surgical centers coming from full to administrative review with the establishment of a new -- there will continue to be full review, but we look for this Council to approve that recommendation and Committee, and we so move.

DR. BERLINER: Second.

DR. STRECK: We have a motion and a second.

Are there questions or comments about the motion and the recommendation as proposed?

Hearing none, I would ask that those who are in favor of the motion proposed to say "Aye."

(A chorus of "Ayes.")

DR. STRECK: Opposed?

Thank you.

Other business?

DR. RUGGE: No.

DR. STRECK: Thank you.

We'll now move to the report of the Committee on Codes, Regulations and Legislation. Dr. Gutierrez.

DR. GUTIERREZ: This Committee is also known as a hypoglycemia committee. The Codes, Regulation and Legislation Committee reviewed a few regulations on September 20, 2012. One regarding Nursing Home Sprinkler Systems for emergency adoption, and one other regulation for emergency adoption prohibiting Synthetic Phenethylamines and Synthetic Cannabinoids, and also the permanent version for information.

The Nursing Home System Sprinkler System regulation was the first one and was presented for a third emergency adoption. It was on for emergency because of a Federal Mandate that specifies that on or before August 13, 2012 all nursing homes must be protected by a supervised automatic sprinkler system. This measure proposed to help financially distressed nursing homes become compliant with the federal provisions and to

incentivize lenders to lend to this nursing home by requiring the payments made be deposited in a dedicated account that is to be used to pay solely for this debt service.

The Committee voted unanimously to recommend adoption to the full council, and I so move.

DR. BERLINER: Second.

DR. STRECK: The motion has been made and seconded in regard to the sprinkler systems.

Is there a discussion?

Hearing none, those in favor of the motion as proposed please say "Aye."

(A chorus of "Ayes.")

DR. STRECK: Opposed?

Thank you.

MR. GUTIERREZ: The next item on the agenda was a proposal on for second emergency adoption that would prohibit Synthetic Phenethylamines and Synthetic Cannabinoids. The only significant change from the previous emergency version was the numbering of the provision set forth in Part 9 of 10 of the NYCRR.

The purpose of this measure is to

prohibit the manufacture, sale and distribution of Synthetic Phenethylamines, or commonly know as bath salt and Synthetic Marijuana. The sale of this substance is continued but now in a more serendipitous manner using a password and behind the counter hidden from public view. Undercover state police operations have found a large number and a variety of vendors located throughout the State, not just head shops.

The regulation defines 13 specific Phenethylamines along with a catchall that would include any compound that has a similar chemical structure allowing the Department and the law enforcement to keep up with illegal activity of those individuals seeking to change the structure to avoid the existing drug law.

Twelve separate classes of Synthetic Marijuana are defined as well. Possession, exception to possession penalties and -- were also discussed. When asked about the penalties of single possession and the rationale for making it part of this, making it part of this provision, Mr. O'Leary responded that the purpose of including simple possession is because of it being sold

behind the counter not in public view. The store owner can get around possession with a viable defense saying that they are not selling it. Mr. O'Leary said that he was not aware of a single instance where someone who is not profiting from the sale from the retail establishment has been a target for this. It is the manufacturers, distributors and sellers who are the target.

The Committee voted unanimous to recommend adoption to the full council, and I so move.

MR. FASSLER: Second.

DR. STRECK: It's been moved and seconded.

Is there further discussion?

Hearing none, those in favor of the motions as proposed please say "Aye."

(A chorus of "Ayes.")

DR. STRECK: Opposed?

Thank you.

MR. GUTIERREZ: The last item on the agenda was a permanent version of the provision to prohibit Synthetic Phenethylamines and Synthetic Cannabinoids on for information, and this version

is identical to the emergency version that is currently moving through the regulatory process and would completely be brought back to the Council for adoption.

That, Mr. Chairman, concludes my report and we can all run for food.

DR. STRECK: Thank you, Dr. Gutierrez.

In your packet for the Council members there's a schedule of the next meetings. You will see Planning on October 30th and November 14th, the Ad Hoc Committee on Health Improvement Plan on the 31st, and then our Committee day on the 15th of November and the full council on the 6th.

If there is no further business for the Council, I would ask are there any comments from anyone?

I thank you for your patience, your creative discussions. So, we are now adjourned for lunch.

(Time noted: 1:35 p.m.)

C E R T I F I C A T I O N

I, SHERRY SPALLIERO, a Court Reporter and Notary Public, within and for the State of New York, do hereby certify that I reported the proceedings in the within-entitled matter, on October 11, 2012, and that this is an accurate transcription of these proceedings.

IN WITNESS WHEREOF, I have hereunto set my hand this _____ day of October 2012.

_____

SHERRY SPALLIERO