NEW YORK STATE DEPARTMENT OF HEALTH

PUBLIC HEALTH AND HEALTH PLANNING COUNCIL

DATE: December 6, 2012

LOCATION: EMPIRE STATE PLAZA
Meeting Room 6
Albany, New York

PHHPC - 12-6-2012 - Albany, New York

(The meeting commenced at 9:45 a.m.)

DR. GUTIERREZ: Good morning. Angel Gutierrez, I'm the chair of the Codes, Regulation, and Legislation Committee and we don't have a lot of time allotted for this committee to function for this particular event. So we have three regulations on the agenda. One is for permanent adoption, one for permanent and emergency adoption, and one for information only.

The first item in the agenda is a nursing home sprinkler system proposal on permanent adoption. Mr. Loftus from the Bureau of Long Term Care Reimbursement will present.

Mr. Loftus, please go ahead.

MR. LOFTUS: Okay. Thank you. This is the permanent adoption of the sprinkler reg that was brought before the committee three times on a -- on an emergency basis. And basically this is an addition to Part 86-2, Part 86-2.41 that because of the federal mandate that all nursing homes be sprinkler compliant with a supervised automatic sprinkler system by August 13th, 2013.

PHHPC - 12-6-2012 - Albany, New York

We propose this regulation to assist nursing homes in obtaining financing by accelerating reimbursement for any facility that was in a financial need.

The comment period ended on this in October. There were no comments from the public and that basically ends my presentation on the sprinkler reg.

DR. GUTIERREZ: Thank you very much, Mr. Loftus.

Any comments from -- or questions from members of the committee or the Council? Are there any comments or questions from members of the audience? If not, I would like to hear a motion to present this. Mr. Hurlbut. A second, Dr. Bhat. All in favor. Anybody opposed? Any abstentions? The motion is carried.

The next item on the agenda deals with a Prohibition of Synthetic Phenethylamines and Synthetic Cannabinoids Prohibitions for permanent adoption. Mr. O'Leary from the Bureau of Narcotic Enforcements will present.

Mr. O'Leary, please go ahead.

PHHPC - 12-6-2012 - Albany, New York

MR. O'LEARY: Thank you, Doctor.

The permanent regulation which is being proposed is identical to the emergency regulation which had been previously adopted by the committee. The purpose of this -- the purpose of this regulation is to ban specific substances known as bath salts. Those are the synthetic phenethylamines, as well as synthetic marijuana, which is classified here in eleven separate categories of synthetic cannabinoids.

These are growing drugs of concern and because of their malleable chemical structure, they have been difficult to place into legislation, something that the Department has been pursuing both in the last term and will do so in the upcoming legislative term.

Since the initial adoption of the emergency regulations in August of this year, the Department has worked closely with the New York State Police in enforcement conducting undercover operations. The State Police have and have worked closely with our forensic chemists and toxicologists within the Department. We have seen

significant sales of this throughout the state, and we do expect shortly to have enforcement actions. Other than that, that concludes my presentation.

DR. GUTIERREZ: Thank you very much, Mr. O'Leary.

Any discussion from committee or Council members? If not, are there any questions or comments from the audience?

Seeing none, I would like to hear a motion. I have a motion and a second. All in favor? Anybody opposed? Any abstentions? The motion carries.

Now the emergency version of the same proposal is now on the table. And the reason for that is we need this, since a previous emergency is lapsed or about to lapse, we need this to cover for the permanent -- before the permanent comes into function. Are there any questions from the committee or the Council?

Any questions from the audience?

If not, I'll like to hear a motion. Mr. Hurlbut. Second, Dr. Bhat. All in favor? Anybody opposed? Any abstentions? And the

PHHPC - 12-6-2012 - Albany, New York

motion then is carried.

The last item on the agenda is a proposal only for information regarding ionizing radiation. Mr. Gavitt from the Bureau for Environmental Radiation Protection will provide the overview.

Mr. Gavitt, please?

MR. GAVITT: Excuse me. Good morning. We are proposing to amend Part 16 of the State Sanitary Code. Part 16 deals with ionizing radiation. The proposal deals with two components of Part 16. One is the use of radioactive materials and the other is the use of ionizing radiation produced by machines.

The radioactive materials portion deals with human use. What we are proposing is to amend the regulations to be compatible with federal regulations, so there's a -- a number of -- of clarifying changes in the definitions. Also just recognition of federal regulations dealing with this same use, New York State is an agreement state with the U.S. Nuclear Regulatory Commission as part of that agreement. We must maintain compatibility.

PHHPC - 12-6-2012 - Albany, New York

So the medical use of radioactive materials, mostly diagnostic nuclear medicine, is to basically to update those regs and be compatible with -- with federal regulations.

The other component deals with the radiation therapy, mostly external being linear accelerators as well as brachytherapy. We're amending the regulations to update them to be consistent with the current machines and protocols that are being used by medicine today to address -- to address errors that we have found with quality assurance requirements for transfer of data from treatment planning machines to the treatment -- the computer planning machines.

So part of that requirement will require credentialing of individuals. It will require that they update their quality assurance requirements. And also it will require that any facility providing radiation therapy be accredited by the American College of Radiation and Oncology or American College of Radiology.

These regulations have been put forth for comment to the regulating community and

PHHPC - 12-6-2012 - Albany, New York

we have not received any comments on the proposal. That concludes my presentation.

DR. GUTIERREZ: Thank you, Mr. Gavitt.

Are there any questions from committee members or from Council members?

Are there any members of the public that wish to make any comments or questions?

Hearing none, we conclude the discussion and this concludes the Codes and Regulation Committee deliberations.

Do I have a motion to adjourn? So move and then we conclude the meeting. Thank you very much. We have time extra?

DR. RUGGE: Good morning. The Health Planning Committee is awaiting a quorum. We believe we have members coming on Amtrak and should be arriving very shortly. But we will take a brief pause unlike us, but we will pause and convene very shortly.

(Off the record)

DR. RUGGE: One hundred and ninety-seventh meeting of the Health Planning

PHHPC - 12-6-2012 - Albany, New York

Committee or PHHPC. As everyone knows, we missed meeting one ninety-five due to hurricane Sandy and therefore scheduling this meeting to take perhaps a last look at -- at recommendations that we are proposing to present proudly to the full Council in a few more minutes -- actually in another couple of hours.

Because we have such a compressed agenda, I think everyone in the Council and members of the public have available to them a forty-three -- forty-four page report that was sent as draft. As it happens, the committee did adopt or for recommendation Recommendations One through Sixteen of some twenty-three recommendations. The committee met in session last Friday to consider the remaining recommendations and work through them, but we lacked a quorum for formal adoption.

The process today is to entertain a motion to adopt the full report and then we will obviously be careful to allow the time for the necessary discussion, especially with respect to any recommendations that have not yet been adopted by committee, Number Seventeen through

PHHPC - 12-6-2012 - Albany, New York

Twenty-three.

I would hope that we may have a motion to adopt, a second, and then opportunity for amendments and a bit of refining of language with respect to one or more of the recommendations. Is there a recommendation to -- or is there a motion to adopt? We have a motion. Do we have a second? Motion and second.

By way of starters to set a good example, with respect to health planning, Glens Falls Hospital has indicated a desire to work closely and participate in the Capital Region Health Planning District. And I would like to propose as a friendly amendment that Glens Falls Hospital should be specifically cited as having available to it participation if it would so wish to participate in both Regional Health Planning -- Regional Health Improvement Collaboratives.

We have a -- is this acceptable to the motion maker? We do. Are there any other proposed amendments or changes to the recommendations as presented in draft?

Jeff, it's your turn.

PHHPC - 12-6-2012 - Albany, New York

MR. KRAUT: I think -- I'd -- I'd like to come back on the passive parent and make a -- a few amendments, and this is Recommendation Number Seventeen. And I'm not sure, depending on which version you have, what page this is in, so let's just make sure we're getting there. Recommendation Seventeen in the black line document is on page -- it begins on page thirty-seven and I -- my -- my comments begin on page thirty-eight.

And I'd like to strike out the -- the paragraph -- it's -- it's kind of -- a part of the paragraph on -- let's see if I -- I have this right. Is it thirty-eight or thirty-nine? I'm sorry. Thirty-nine. It begins the second paragraph, the Council notes that I'd like to strike out the reference there to -- that talks about the clinical integration. In the first bullet -- so I want to strike out that paragraph and amend the first bullet to talk about seeking to affiliate with a passive -- this is the last line of that, the passive parent as well as the broader health care system.

This is just kind of little word

PHHPC - 12-6-2012 - Albany, New York

changes. On the last bullet of that paragraph, I want to have a little clarity on the grounds for -- for disapproval, so it's recommending disapproval. I would insert the word recommending disapproval, would be a poor record of compliance, integrity, financial management, or quality on part of the passive parent or its affiliates.

I would strike out a lack of sufficient financial resources within the system. And -- and the reason I'm suggesting that is -- is the conversation we had at the meeting where we didn't have a quorum where we discussed part of the reasons for these organizations to come together at times. They may have insufficient resources and the combination of the two may, in fact, produce a stronger organization. But if you just looked at pure numbers and looked at the relative weakness that -- that it might fail based on the words we had chosen.

I then continue on the next paragraph and I would suggest that it's very hard to enter into these type of relationships, deal with all the issues that you have to do in creating

PHHPC - 12-6-2012 - Albany, New York

new governance relationships and then say there's a three-year time limit. Because depending on which entity is -- is -- is adjoining or acquiring, there's an enormous amount of energy to be put in. And to think that you could make those investments and that you just have a three-year time limit, so you have to -- I think, on a lot of these things you have to have a longer view of it. So here instead of having a time limit, I would suggest that we now basically say the relationship would be reviewed every three years. So you -- you have an opportunity to review and see how it's going, but the suggestion would be if everything's going well, it -- it keeps moving forward but there's no expiration of -- of that. And we would strike out the next line requiring the expiration and request for expansions.

And then in -- in reviewing, just to add in the -- the financial management, as opposed to the stability of the organization and the failure to meet the standards, could result in a revocation of a passive parent approval or other action. And we take out the requirement of

clinical integration. Clinical integration, in my mind, which is essential and important for all the reasons described in -- in the document, should occur at -- at a -- at a pace in time that -- that has let the organizations make those decisions. So there -- there's an expectation of clinical integration, but there's not an absolute here issue.

And then I'd go lastly onto the next page on -- that the affiliates with -- with existing passive parents we're going to remove the -- the -- the notion will be subject to a time limitation, that existing relationships also have that same three-year review. And I would suggest to delete everything that follows to the end which really gets involved in, I think, what we had discussed last time, issues outside of the purview of necessarily the -- the Council, certainly, and the -- the Department of Health dealing with some of the issues of F.T.C. and antitrust. I think it just kind of confuses some of the intent here.

I've written and have this typed up. I'll -- I'll offer it and -- but -- well -- so

just to kind of summarize, remove the reference to the antitrust. Remove the reference to mandatory clinical integration. Remove the -- the time limit on it, and I have language here to -- to effectuate that.

DR. RUGGE: Dr. Gutierrez?

DR. GUTIERREZ: I -- I understand what is being presented, but I am not sure that I understand where these things are being changed. I -- I think you moved too fast and I could not reference it in my papers here.

DR. RUGGE: We -- we may need a bit of discussion here, just to be clear. If the committee becomes satisfied that these modifications to substance are appropriate, staff will distribute to members of the Council and to the stakeholders and members of the public who are here precise language to indicate the changes that Mr. Kraut has -- has pointed to.

Again, as everybody -- I think almost everybody here knows, this committee has had very detailed, sometimes excruciating discussions point by point on all twenty-three of our

recommendations. Of these, we have spent the most time regarding passive parents, substantial parts of four meetings, coming to realize this is a very complex issue, in part because of the variations and complexity of existing arrangements among providers established and -- and not so established.

At each of our committee meetings with the redrafting and with the benefit of extensive discussions amongst stakeholders and members of the committee, it would appear that we have arrived at language that reflects the substance and -- and a -- and I would venture a consensus of all the views that we've heard over those -- those four meetings.

Perhaps we could have Karen just briefly summarize or read into the record the proposals that -- they -- Jeff is itemizing.

MR. KRAUT: And -- and, John, I just -- I'm going to have another one that Art Levin asked me to share.

DR. RUGGE: Yes. We will do that -- we will do that next.

PHHPC - 12-6-2012 - Albany, New York

MR. KRAUT: Next. Okay.

DR. RUGGE: But this is in preparation for -- for Dr. Gutierrez to consider whether he would accept as a friendly amendment the following revisions to Recommendation Number Seventeen.

Karen?

MS. MADDEN: Can everyone hear me? Okay. Why don't I -- I think I can start by sort of summarizing the proposed process in a conversational way and then read in the changes into the record because I think that will help make it more understandable. So I think what is being proposed here is to retain the proposal that prior to the commencement of a passive parent relationship, there would be a notice to the Department with ninety days for the Department to recommend disapproval. If there's no recommendation of disapproval the proposed arrangement would go forward.

The grounds for disapproval are -- are being slightly changed pursuant to this amendment. Instead of the grounds including lack

PHHPC - 12-6-2012 - Albany, New York

of sufficient resources, that would be deleted. The grounds would be poor record of compliance, integrity, financial management in lieu of financial resources, or quality on the part of the passive parent or its affiliates.

The current -- or the proposal in the draft put a three-year expiration date with an opportunity to renew on the passive parent relationships. Instead of a three-year expiration the proposal is that the passive parent relationships would be subject to review every three years but would not expire. The review would consist of compliance record financial management instead of stability, quality of care, and evidence that the passive parent is mutually beneficial. I think I neglected to say mutually beneficial earlier when we were talking about grounds for recommending disapproval. That's included above as well. Failure to meet those standards would -- could result in a revocation of passive parent approval or other -- other action. And then the proposed amendment deletes the discussion of clinical integration. So I'll just read into the

PHHPC - 12-6-2012 - Albany, New York

record those changes.

On page thirty-nine, there is a paragraph that begins the Council notes that some passive parents negotiate. That would -- paragraph would be deleted. The following paragraph remains as is. The first bullet -- at the end of the first bullet the last sentence says it should be asked to demonstrate how the proposed arrangement will benefit the health care facility seeking to affiliate. Delete as well as the. Insert passive parent and its system. Insert as well as the broader health care system.

The second bullet remains the same.

The third bullet says grounds for recommending disapproval and that recommending is inserted would be a poor record of compliance integrity. Insert financial management or quality on the part of the passive parent or its affiliates. Delete or lack of sufficient resources within the system. And the rest of the bullet remains the same.

The following paragraph begins

PHHPC - 12-6-2012 - Albany, New York

approved passive parent relationships would be. Delete subject to a three-year time limit. Insert reviewed every three years. Delete prior to the expiration, and the remainder of that sentence. Delete the beginning of the next sentence, requests for extensions. That's deleted. Insert reviews would be. Delete the word reviewed. Based on the systems compliance record financial, delete stability. Insert management, quality of care, and evidence that the passive parent arrangement is mutually beneficial for the parent. Insert and or its affiliates. Failure to meet these standards could -- oh, sorry. Insert failure to meet these standards could result in, delete A. Insert revocation of passive parent approval or other action. Delete the next sentence which begins implementation of a plan for clinical integration.

And on the next page -- oh, actually it's the same page -- affiliates with existing passive parent relationships, that remains the same until the next sentence, however existing relationships would be subject to, and delete the time limitation and. And retain review -- would be

PHHPC - 12-6-2012 - Albany, New York

subject to review.

The next paragraph relates to clinical integration. The next three paragraphs relate to clinical integration and they would be deleted.

DR. RUGGE: Before proceeding, is that -- Dr. Gutierrez, would you accept this as an amendment to -- a friendly amendment? Just -- just by way of, again, an overview, this recommendation represents a culmination of many, many discussions and many, many editors and contributors, and it does allow for a new level of oversight of passive parent arrangements, but without automatic termination of any such arrangement and clarification of the terms for review.

Dr. Martin?

DR. MARTIN: Thank you. I just want to make certain, because I -- I may have missed something. Karen, when you were going through that third bullet and you took out or lack of sufficient financial resources within the system, we're going to replace it with something about financial management there also?

PHHPC - 12-6-2012 - Albany, New York

MS. MADDEN: Yes. Financial management would be inserted.

DR. MARTIN: Okay. Okay. I didn't hear you say that, so thank you.

MS. MADDEN: Sorry.

DR. RUGGE: Are there any further questions or comments? I believe we have one more addition. Based upon committee discussion on last Friday when there was no available quorum, it was suggested in light of the damage done by Hurricane Sandy, there should be a new look at environmental standards and disaster preparedness for flooding or other environmental catastrophes, given the prospect of global warming and all that comes with it.

And, Mr. Kraut, I believe you have a Recommendation Number Twenty-three.

MR. KRAUT: So this is a -- a new recommendation actually also proposed by Mr. Levin who's not able to join us here today. This recommendation would read as follows. The Council recommends that D.O.H. work with stakeholders to review and update as necessary the construction and

PHHPC - 12-6-2012 - Albany, New York

environmental standards for health care facilities to ensure that patients, staff, and facilities are protected in the event of severe weather events and flooding.

So obviously, the -- the devil is in the details as, you know, they'll look at regulations and how to change based on all the learning that has occurred in a post-Sandy environment.

DR. RUGGE: Dr. Gutierrez?

DR. GUTIERREZ: That's not the only kind of disaster we need to contemplate. What about earthquakes?

MR. KRAUT: I think the -- go ahead. I think --.

MR. SHAH: So the governor has convened several working groups and what this is really is a placeholder for reports of those working groups that will look across the entire preparedness spectrum -- preparedness and response spectrum. Based on that, that could inform the discussions of this body. So this is just a -- let's wait and see what -- what happens from the

experts and then we'll readdress this in the future.

DR. RUGGE: So in effect, we are putting on to our -- to our own work agenda this topic for further deliberation.

Howard?

DR. BERLINER: I think beyond just a review of facilities and -- and environmental preparedness, I think some of the events that transpired may require us to look again at some of the things that we've assumed explicitly or even tacitly about health planning going forward. And not to expand this to the whole world, but, I mean, I think -- I think we should expand that what we're going to do to even to look at some of the basic principles of health planning that -- that -- that we have used historically that may be changing in light of -- of these changing conditions.

DR. RUGGE: Yeah, it would certainly seem based on your remarks and our experience that -- that adding this is yet another agenda item for our new regional health improvement

PHHPC - 12-6-2012 - Albany, New York

collaborative. All the more justifies their establishment.

Dr. Martin?

DR. MARTIN: Well, I was just going to say something similar. We brought it up at our last meeting was all -- the concept of disaster recovery. I mean, clearly we need to talk about building buildings that don't fall down and can survive, but when do -- when bad things do happen, the ability of the system to recover from it both at a facility level and as a regional level is something that we need to focus more on and review.

I understand what the commissioner said that this is basically just to say we're aware of it and we're going to do it. It is for the record to say that it's not just the brick and mortar or even the wires and the electronics, but it's everything else that goes to bring something back up when it's no longer there.

DR. RUGGE: For the record, Dr. Gutierrez, are you willing to accept this as a friendly amendment? Okay. To be clear, there's

PHHPC - 12-6-2012 - Albany, New York

some redundancy today that Council will be returning to this report to further discuss it. If there's no further discussion by the committee, I would welcome any -- sorry. Sue?

MS. REGAN: I'm -- I'm not on the committee. Were you going to --.

DR. RUGGE: Feel free.

MS. REGAN: Oh, okay. I do want to say I think this is a wonderful piece of work. And some of these modifications have been -- will -- will fix things that have plagued us for years. And among those is the character incompetence review. I -- I think that the tenure taint has been a source of a lot of agita (sic) and I think this will go away as to fix it.

But what I would like to propose is adding in something that has always been sort of handled by presumptions. And that's a finding of character -- finding of good character. When we would have an applicant come -- and my involvement before the establishment committee, there was an assumption that their character was good unless we had not only evidence, but we had to have virtually

PHHPC - 12-6-2012 - Albany, New York

a conviction. I mean, they had to practically be in jail before we could keep somebody from opening a nursing home or whatever it was they wanted to do.

And I do think I would like to see in this report some effort to boost this -- this Council's ability to -- with a -- with a finding -- factual finding of evidence of the sort of misconduct that doesn't rise to the level of criminality, but is clearly something we would all agree upon as being evidence of poor character. And the things that came to mind from the years that -- of my experience at least were knowing violation of a condition of licensure. That's something I think we could objectively show. False statements on self certifications. And, again, as we move to self certification, there has to be a very -- very quick and bold statement that if you lie on the self certification, God help you. Because they're going to -- there's going to be that. So that, I think, should support a finding of poor character.

Improper or illegal efforts to

PHHPC - 12-6-2012 - Albany, New York

influence officials, which we know happens. There are lines that should not be crossed. When they're, crossed we should know about it. Transfers of ownership or other economic interests for the purpose of avoiding taint. We've closed our eyes to some of that in the past, and I think the reason we did is because we didn't feel we had the ability under the existing regs to do anything about it. I think it's wrong, and I would like to propose that we add language along -- I'll just read what I drafted, but obviously it's subject to discussion. Further refinement is recommended in reaching a determination by the PHHPC regarding the character of operators. Evidence to rebut a finding of good character might be findings such as -- and then those four that I listed.

DR. RUGGE: Dr. Gutierrez, would you accept this as an amendment?

Yes, Mr. Kraut?

MR. KRAUT: I -- I thought we had in the report established the policy parameter. I think what Sue is saying is hundred -- you know, you're on target and you're right, but wouldn't

that be discussed when we develop the regulation? I mean, you know, there -- there's a level of detail we -- we have to get into and I -- I think the intent is there. Forgive me if I'm -- you know, if you don't agree, but -- but just to get us -- because now, you know, we're -- if we're going to offer information that we haven't been able to get through it as -- as -- as a committee and we -- then we have to allow the public to comment on it. You know, I -- I'd like to make sure that all the work we've done gets out and approved because we're going to have to -- as a practical manner, I -- I don't think -- I think people will have opinions on this, right or wrong. And we would -- that might just hold up our -- our thing. So -- so if -- if there's a way to, you know, maybe toy with the language, but that's -- because I think when the regulations come back to us on a lot of these issues, that's when we're going to get into some of the meat of how are we going to do this.

MS. REGAN: Right. No, I would -- I would be happy if we could just put in

PHHPC - 12-6-2012 - Albany, New York

further refinement is recommended in reaching a determination by PHHPC regarding character. That's all I'm trying to.

MR. KRAUT: I think that's -- I -- you know, John that's up to you.

DR. RUGGE: That's -- that sounds good to me if we -- if we have our motion maker and approval.

Dr. Gutierrez?

With that being said, I would invite members of the public to make any comments that they would wish. Expressions of enthusiastic support are especially welcome.

Ms. Waltman?

MS. WALTMAN: Good morning. Susan Waltman, Greater New York Hospital Association. I do enthusiastically endorse.

DR. RUGGE: Thank you very much.

MS. WALTMAN: I do -- I just -- I also thank you very much, obviously, for all the time and the expertise and -- and the effort that went into helping design a report and recommendations that is aimed toward moving the

PHHPC - 12-6-2012 - Albany, New York

health care system toward meeting the triple aim. I -- I recognize that we all want more time. We do, too. We all wanted more time to spend on the report and the recommendations with respect to -- to this because it covers so much ground.

We, as an organization that tends to take studies and report cards and analyze them and put a context on them and add an update, don't have that opportunity, as you don't either as well. But acts of God and nature compress the time that we have to work on this. So I think it just behooves us. And I don't mean to get ahead of the committee or the Council. Those portions of the report or the whole report that you embrace, it just means that we do need to spend more time moving forward with those details and ensure an efficacious and efficient way of -- of implementing these recommendations regulatory, statutorily, or otherwise.

I have four sets of very quick comments to make and I hope you will indulge me, please. I know you have limited time, but it's important what's covered here. We do

PHHPC - 12-6-2012 - Albany, New York

enthusiastically endorse health planning. How can you not? How can we not endorse planning? Our members put forward, as many others did too, concerns about it not being a bureaucratic regulatory process, have another regulatory layer, and not being linked to C.O.N. unless you were part of the state that wanted to do that. And I think you have listened to that and you have committed to that and we appreciate that, and we look forward to moving forward in that regard.

In the area of C.O.N., a couple comments there. We asked for, going back to the beginning of the year, for certain things to be taken out of C.O.N. And we appreciate and I thank you again for being willing to take construction regardless of cost out of the certificate of need program unless there are pieces of that project. And I hope they can be bifurcated, that might be cost drivers or limit access and that's very much appreciated. I know it has required statutory changes, but I thank you for that.

In the category of adding things in, which isn't quite what we were asking for, but

PHHPC - 12-6-2012 - Albany, New York

I know that's a part of the report that is suggested here, perhaps looking at further regulation of physician practices which is something futuristic to review, I just ask that as you look at those issues, and I know you will do this, to confer with the appropriate stakeholders, physicians, medical schools, hospitals, and others as you venture there.

As for adding criteria for C.O.N., it -- I cannot argue and we cannot argue with the criteria that are listed. Adding quality, for example, but you -- you note that there are -- we note that there are -- that's against benchmarks that have not yet been developed. We can't argue with electronic health records and linking to the shiny, but some of that doesn't quite exist and it's expensive and it needs to be tailored to the application.

And requiring people to talk about their aiming for the state and health improvement plan initiatives, that makes sense too, but it needs to be tailored to the specification application. So that's the devil in the detail

kind of thing.

Finally I just want to say on C.O.N., the biggest issue isn't so much what's in what's out, but it's the streamlining and it's the -- the re-engineering of the system and making it work well and quickly that's very important. I just want to thank those at the table from D.O.H. and otherwise who have helped streamline and make it a better process and move more quickly and that's exceptionally important.

Governance -- I'm almost done guys -- governance, that's -- was an area perhaps we did not expect to have so much discussion about or so many areas covered. There is a provision in here that would require statutory language to remove board members and put in place temporary operators under certain very extraordinary circumstances. I just want to say and it's not necessarily the purview of the committee, but there were discussions about this last year as part of the budget process. There were procedural safeguards that were negotiated for that purpose and additional standards. I am hopeful that the

PHHPC - 12-6-2012 - Albany, New York

State of New York will start with that particular formulation as we move forward.

On the issue of passive parents, yes, that was something that took a lot of time. It was concerning. It is concerning to us. The abuses that were perceived were things that I think can occur anywhere along the continuum, freestanding affiliations, contracts, passive parent, active parents, so it became a little bit of wondering why the focus was there. And I would suggest it falls in the category if you see something say something. I'm not sure we need the regulatory framework here, but I will also say that it's been revised, it is acceptable at least with the members that I've spoken with who have these configurations. And I do embrace, as you indicate, the rationalizing of character incompetence, but as that is required of new board members, I do look forward working with the Department of Health to make that a more streamlined process so as not to deter new board members coming on who you want who are the most experienced perhaps in the world.

And finally, on your newest

PHHPC - 12-6-2012 - Albany, New York

recommendation, Number Twenty-three, with respect to looking at our buildings and our -- and our codes for -- for health care facilities, yes, indeed, I do want you to know we're -- we're very much looking at that because of the experience. And it's something that the State Department of Health has been looking at for several years and they have inspected buildings. And they have set standards. So it's not as though it hasn't happened before. We had our generators in the right place. We had submarine structures perhaps around fuel supplies and -- and -- and switches. And it didn't matter. So we've got to look, we've got to look hard, and that's going on. There's a call that the A.H.A. has this afternoon. We look forward to working on that but, again, I thank you very much. I look forward to working on the implementation of these recommendations and thank you for the opportunity to provide input.

DR. RUGGE: Thank you. The -- the favorite part of this report for me is the last paragraph of the executive summary. And it states this report is not intended to be the final word on

PHHPC - 12-6-2012 - Albany, New York

regulatory reform. It is to lay the groundwork for an extended conversation on public oversight of a changing system. And we look forward to continuing this deliberative process.

Mr. Heigel?

MR. HEIGEL: Good morning. Thank you. Fred Heigel from HANYS. I was sitting here listening to the discussions at the meeting and -- and looking at the notes I prepared for presentation today and you've already taken two of our comments off the table. I'd like to thank Dr. Rugge for his recognition with respect to Glens Falls Hospital's participation in -- in multiple regions.

Also with respect to the modifications on the passive parent issue, we appreciate the resolution that was -- that was addressed there. As Susan described, we, you know, certainly believe the Department doesn't have a lack of authority over health care facilities that it -- that it licenses. And I just want to reference the discussions, negotiations of last spring that Susan also referenced regarding the

PHHPC - 12-6-2012 - Albany, New York

powers to dismiss, appoint individual board members and receivership, and echo her hopes that we can go back to where that ended up in the spring with respect to the resolutions Number Nineteen of the report.

We -- we certainly like to see more C.O.N. streamlining, more leveling of the playing field. I -- I understand that's, you know, going to be the discussion for the next phase of this. We appreciate the participation in these discussions.

To the first phases -- first two phases, HANYS has submitted seven sets of written comments, testified at virtually every one of these sessions, had input all along the way. We appreciate that. We'd like to continue that. You know, and I think, you know, we'll have the phase three portion dealing with leveling of the playing field and there will also be implementation of this series of twenty-three recommendations. And we'd like to continue our efforts working together with the State to -- to effect the implementation.

And -- and also I'd -- based on

PHHPC - 12-6-2012 - Albany, New York

the inclusion of Number Twenty-three this morning, we'd like to indicate our support for that one as well. Thank you.

DR. RUGGE: Thank you very much.

Mr. Hime.

MR. HIME: Thank you, Dr. Rugge, committee members. Appreciate the opportunity to comment this morning. I'm with Waiting Age New York. In the interest of C.O.N. reform -- in the spirit of C.O.N. reform, I'll streamline my comments as well.

We -- we very much support the overall direction and framework as espoused in the report. However, there are some elements of the final draft that we're concerned about. With respect to Number Fourteen, Rationalizing Taint, we certainly support reducing the timeframe to seven years and looking for patterns of noncompliance and lapses in quality. However, we're not sure whether or not the criteria for assessing organizational performance will be any less exclusionary than what we have now. So certainly we'll be interested in seeing how the regulations kind of play out.

PHHPC - 12-6-2012 - Albany, New York

And we really would, as we've talked about in our organization, you know, we certainly want to utilize this provision to keep out the bad actors. And perhaps there's a way to consider something like an -- an excluded list. We certainly have exclusion lists for the Medicare and Medicaid programs and this is an approach we just may want to think about because obviously there are -- are opportunities in the system for people who we may not want to have in these governance positions to move among organizations.

Under Number Fifteen, Streamlining Character Incompetence for Established Not for Profits, we are concerned about the review burden being shifted to providers. And, you know, again, the level of detail in the report, it's hard to tell what the criteria will be. We hope they will be very clear and very specific and that this won't wind up being like a background check. And, again, the notion of an excluded list might be something we would want to consider.

Recommendation Sixteen, which is Character Incompetence for Complex Organizations

PHHPC - 12-6-2012 - Albany, New York

and Twenty-two on Revenue Sharing, you know, again, we want to just be on the record that we are -- we remain strongly opposed to publicly traded corporate operation of long-term care facilities and ownership by private equity firms. Obviously, there would need to be changes in statute for some of those things to be allowed. However, we're concerned that these recommendations -- or we're concerned that they could signal a direction that we would want to move to more of these types of arrangements. And that's something that, again, we would remain concerned about.

Under Passive Parent, Number Seventeen, you know, we had planned to bring up the -- the three-year limit. We're very pleased to hear that the amendments are being made this morning. Obviously, we'll be very interested to see what -- you know, what the reviews are going to look like and what the standards will be.

And then finally, some of our members are certainly moving forward, many of them with -- what electronic health records and -- and deploying. However, long-term care as a field is

PHHPC - 12-6-2012 - Albany, New York

behind, certainly, acute and primary care in that area. So with respect to Recommendation Number Twenty, we would echo the comments made earlier that we want to make sure that we can move forward in a productive fashion in deployment of the H.R.

So with that, I appreciate your --

DR. RUGGE: Thank you very much.

MR. HIME: -- the opportunity and we'll continue to work with the Council and the Department.

DR. RUGGE: I -- I think it's fair to say that your input and that of the other stakeholders will be welcome as these policy directions enunciated through this report are translated into new regulatory structures. So the -- the conversation goes on and on.

MR. HIME: Right.

DR. RUGGE: Thank you.

MR. HIME: Thank you very much.

DR. RUGGE: Mr. Cleland? Rich Cleland, is he in the room? If not, we have Nancy Victor.

PHHPC - 12-6-2012 - Albany, New York

Thank you very much. With that and understanding the full Council will have opportunity to both discuss and vote later today, I would propose to call the question and ask if from members of the committee to support the report to vote aye.

FROM THE FLOOR: Aye.

DR. RUGGE: Are there any nays? Do we have any abstentions? Do we have a motion to adjourn? Thank you very much. We stand adjourned and we will be reconvening as a full Council. Thank you very much.

DR. STRECK: Act quickly if you want one of these records.

There are some suggestions or ground rules toward making our meeting successful. There is synchronized captioning. It's important people do not talk over one another. The first time you speak, please identify yourself as a Council member or a staff member. This is of assistance in the broadcasting. And as we've noted before, the microphones are hot so they pick up every sound, rustling of papers, unintended

PHHPC - 12-6-2012 - Albany, New York

conversations, so please pay attention to that.

There's a record of appearance form for our audience that is outside the room. It's required by the Joint Commission on Public Ethics in accordance with Executive Law 166. We would ask you to fill out that form. Thank you for your cooperation in that.

Now I will move to our meeting, which today will be a full meeting covering a number of topics.

We will begin with the Department of Health reports. We will hear from Dr. Shah. Ms. Westervelt will give an update on Office of Health Systems Management activities. Ms. Block will report on the activities of the Office of Health Information Technology Transformation. And Dr. Birkhead will give a report on the activities of the Office of Public Health.

Under the category of Public Health Services, Dr. Boufford will present to Council a very important result, that being the prevention agenda for 2013 through 2017. And the State health improvement plan for adoption, we will

take some time to review and discuss that. We will consider -- under regulation Dr. Gutierrez will present regulations for emergency adoption and discussion.

About that time, we will break for lunch. That will be, by our projection, somewhere between noon and twelve thirty. We'll allow thirty minutes for lunch; then we'll return for the project review recommendations and establishment actions. Mr. Kraut will chair that committee's report. And then we will turn to the health policy field and Dr. Rugge's planning C.O.N. redesign report, part of which was completed this morning and the full recommendation forwarded to Council moments ago. We anticipate that that will require some fair amount of discussion so we are trying to orchestrate our time to allow that to effectively occur.

I would point out that -- to the Council members if we have conflicts on any applications, please make sure you've noted that. We will go through our usual batching process to try to expedite thoughtful but review of

PHHPC - 12-6-2012 - Albany, New York

applications in an efficient way. And I'll make sure that all the Council members this moment have noted any conflicts.

With that, I would ask for adoption of the minutes of the October 12th meeting. These are on the Department's website. And I would -- any further discussion? Those in favor, aye.

FROM THE FLOOR: Aye.

DR. STRECK: Thank you.

It's now my privilege to take a moment for a resolution of appreciation. This is Rick Cook's last Council meeting as he is retiring from state service. Mr. Cook, as we all know, is a highly valued colleague and a member of the department staff and we should be honored that he's chosen to mark his departure on the very day of this Council meeting. It will be difficult to see him leave, not only for his institutional knowledge, management skills, and the expertise he has brought, but for his concern for the health and safety of the residents of New York, and I would add for his conscientious attention to the needs of

PHHPC - 12-6-2012 - Albany, New York

so many. On behalf of the Council, Mr. Kraut and I have signed a resolution of appreciation for Mr. Cook which I will now read for the record and for Mr. Cook.

Whereas Richard M. Cook has served the citizens of the State of New York over the past twenty years beginning his state service as a senior health advisor to the majority leader of the New York State Assembly, negotiating the state's Medicaid budget and rate setting systems, From 1991 to 1994 Mr. Cook served as Governor Mario Cuomo's assistant deputy secretary for health, advising Governor on health care policy and program development.

Mr. Cook left state government for Albany Medical Center where he served -- served for twelve years, and in 2006 was appointed executive vice president for policy, planning, and communications. In January of 2008, Mr. Cook returned to state service as the Deputy Director of the Office of Health System's Management. In 2009, Commissioner Danes recognized Mr. Cook's immense knowledge and dedication and appointed him to serve

PHHPC - 12-6-2012 - Albany, New York

as the Deputy Commissioner of the Office of Health System's Management.

His work in the Department of Health spanned the administration of Commissioner's of Health Richard F. Danes and Dr. Shah. Under Mr. Cook's leadership there were countless successful initiatives in many facets of health care, always with patient safety and quality and robust health planning to underpin the efforts.

Notably, Mr. Cook led the modernization of the certification of need process, including the merger of the State Hospital Review and Planning Council and the Public Health Council into the Public Health and Health Planning Council. He oversaw the certificate of need streamlining initiative and implemented an electronic submission process for certificate of need applications. Mr. Cook also directed efforts in changing the State's adverse reporting program to align with national benchmarks and advocated for accountability and transparency for health system governance.

Whereas members of the Public Health and Health Planning Council recognized that

PHHPC - 12-6-2012 - Albany, New York

during his years with the Department he has demonstrated a strong commitment to the development of innovative programs, new services, and an efficient and high quality health care system, which has made a positive difference in the lives of all New Yorkers, and whereas Mr. Cook's exceptional leadership, expert advice, and his dedication to strengthening the health care system has furthered the Council's endeavors to improve the health for the citizens of New York State, and whereas Mr. Cook's integrity, resourceful, diplomacy, work ethic, and professional demeanor under all circumstances has garnered the much deserved respect of the Council and his colleagues, now be it resolved that members of the New York State Public Health and Health Planning Council wish to convey their appreciation to Richard M. Cook for his dedication, diplomacy, and for his selfless service to the citizens of our state.

And be it further resolved that the members of the New York State Public Health and Health Planning Council feel privileged to have been able to serve the citizens of New York State

PHHPC - 12-6-2012 - Albany, New York

with Richard M. Cook whom they hold in the highest esteem as both a friend and a colleague and offer best wishes for his future health, happiness, and professional achievement. Thank you, Rick Cook.

MR. COOK: Are -- are you going to take a vote on --? Well, I -- I thought it would be interesting to hear from some Council members who weren't appointed to the new Council, but --. Thank you very much. It's been a pleasure. I think the one thing that you realize in these jobs is that they're shaped by the people who came before you, Grace Sweeney, Dennis Whalen, Wayne Osten, (phonetic spellings) and they're shaped by the people who stand behind you.

And, you know, I think that was the greatest pleasure is -- is just the people you get a chance to work with. And all the wonderful things you said are terrific, but we all know that none of those things get done without a great many people who stand behind people like myself every day, stand with me, and are so committed to improving the lives of New Yorkers. So for that, I thank you.

PHHPC - 12-6-2012 - Albany, New York

MR. STRECK: Thank you, Rick. We'll now move on, beginning with a -- a series of reports. And it's a pleasure to hear from Commissioner Shah who will update the Council about the Department's activities since our last meeting.

Commissioner Shah?

COMMISSIONER SHAH: Thank you. There's a lot I'd like to get through and so I will try to give its due to all the different things the Department have been working on in the last few months. But I -- I fear I will not be able to do justice.

I want to start by talking about Sandy and a lot of folks in this room, on this Council, and in the audience were directly involved in the response. This was historic. It has been an all-hands-on-deck effort for the Department of Health for the last month and a half and it continues. And I -- I want to give some flavor of the scope of the response from the health care sector's perspective.

So, you know, before the storm in the last year and a -- since Irene, we've been

PHHPC - 12-6-2012 - Albany, New York

working very closely to -- with nursing homes and other facilities to update planning, to update their preparedness plans, to make sure generators were up and running, to make sure that the -- the zones were reclassified. And -- and that really actually led to a much favorable position when this storm hit.

When -- last year with Irene, we had facilities who had great plans in place, but when the same ambulance companies contracted with three different nursing homes to evacuate, they can't reach all three nursing homes. Those kinds of issues were addressed, resolved, and a lot more was done behind the scenes that you will not hear of to really strengthen the resilience of the health care community in the past year.

There's something we call an incident management system. And this was instituted on the 26th, well in advance of the storm, with twice-daily calls statewide with subject matter experts talking about every potential outcome and every phase of the response from the beginning through the end. These

PHHPC - 12-6-2012 - Albany, New York

continued through -- and we've had now twice a day through November 20th, these incident management calls led by the Department of Health.

We had three different centers where we coordinated the response. One was the HOC, the health care operation center in Menands. One was the Bunker in Albany. This is along with all the other state agencies. It's classified. I can't tell you where it is. And -- and the third is in Brooklyn and it's called the HECC, and it's the health care facility evacuation coordination center. This is at the city O.E.M. offices and it's in coordination with the mayor's office with FEMA, LIPA, Con Ed, about forty other groups that are physically positioned there. And we had between twenty and thirty people there throughout the duration of the storm and in the recovery phase.

And -- and I think it's important to see right in the middle, Farley and -- Commissioner Farley and myself were physically there together and that really helped in coordinating the city state response. We were able

PHHPC - 12-6-2012 - Albany, New York

to work with all providers. We were able to work and have phone calls with unions, with others, thanks to the help of Susan Waltman, Lee Pearlman, Greater New York, and many other provider groups that physically manned that station with us.

I'm going to try to skim over some of these facts because all of these web -- all of these statistics will be available and the slide that will be available on our website. But there were over eighty thousand notifications in the time leading up to the storm. This is not even the time period after the storm hit or -- or before the snowstorm or -- or subsequently. But the -- the -- the level, the degree, the magnitude of response and -- and conversations and follow-up and surveys was incredible.

To manage all of that data real time and to act on it is certainly challenging, but there are systems in place to make that happen. We work with the institutions in the zone directly affected with four-hour -- every four-hour phone calls for the duration of the storm. Certainly, there were periods when we couldn't contact some

PHHPC - 12-6-2012 - Albany, New York

facilities, but to the level that that -- that was all coordinated across all different sites using real time updates on Internet websites that are secure. It was incredible response that evolved from Irene so that we were more secure in where facilities were relative to prior efforts. And -- and we physically sent folks out to those areas, both before and after the storm to make sure facilities had the generators, they were working, they had the staffing and -- and afterwards just to help in the response.

We -- I am going to move closer because I actually never wear glasses, but I can't really see. So we -- we had over several thousand folks relocated both during and immediately after the storm. And this was another success story where despite the huge transitions -- and we know the real problems of moving these individuals, that there are issues involved. And there's a very specific ratio beyond which you don't want to evacuate people if you don't need to. And -- and despite that, despite the large movements, we know -- I know of one fracture that occurred during

PHHPC - 12-6-2012 - Albany, New York

the moves and I think someone slipped and fell, but other than that there were no injuries or deaths in all of those relocations because of the relocations. And that's a testament to the frontline providers who despite hurrying to get people out of harm's way had the policies in place and worked together to ensure the safety of all the residents from all different types of facilities.

And -- and I'm talking about NICUs being evacuated. Little babies on ventilators, walking down the stairs, cradling them, and yet, you know, positive outcomes. This was an incredible, incredible response. Bellevue alone has -- well, stories for another day and -- and some of you have heard these stories, but let's -- let's keep going.

Our website was our primary means of communication. It worked well. We were able to keep the information posted up to date and it continues to be playing a more and more important role in our communication. Social media, there's a new role for social media. We found, for example, with the Park Slope Armory, we had a number of

individuals who required kosher meals. And with a few tweets they were able to get the whole community in Brooklyn delivering kosher meals to the Park Slope Armory beyond the -- the -- we had actually a very nice store of frozen kosher meals, but fresh kosher meals to supplement that. So the power of social media in response is going to really change the nature of the game in the near future.

What -- after the storm hit -- made landfall, that's when the communication that we had established really showed its strength, with the mayor's office, with the city, with the state all working together to ensure coordination with all of the different provider groups reaching out to make sure that we had the best available knowledge out to everyone in the real time made it much easier than it could have been.

There were over two dozen nursing homes that were evacuated. Almost two dozen adult care facilities evacuated and ten large hospitals that were evacuated. From the Department of Health in -- in addition to coordinating those

PHHPC - 12-6-2012 - Albany, New York

evacuations, we had epidemiologists working to see in real time what the needs were. So, for example, we were worried that there was an unmet dialysis need, but we could monitor in real time the number of people who showed up in emergency rooms with the chief complaint of requiring dialysis. And we were able to, with the Association's help, get in advance of that. And actually there were several thousand people who received dialysis on Sunday prior to the storm despite dialysis centers usually being closed because of that request that went out from the Department, and because providers were able to get up and running. So despite many of those centers going down, it was not the emergency that it could have been because we worked together and we were monitoring that data in real time.

We were also able to monitor things like hypothermia, carbon monoxide poisoning, all of this in real time, and address resources appropriately, whether it was pharmaceutical refills, and so on and so forth. There's a lot of back end there. Very interesting story there.

The call centers and help lines

PHHPC - 12-6-2012 - Albany, New York

were also -- stood up in real time and they were also -- we're continuing them. For example, right now we're continuing to get calls to the tune of fifteen to twenty calls a day regarding mold and remediation, but it's not really been an overwhelming number or spike as some people might think.

But the -- the centers do exist and we are tracking all of these data in real time. The disaster recovery centers were an important part of our outreach. They were able to meet unmet mental health needs, which was the primary need initially after the storm for a lot of these affected populations and for the first responders.

Mental health continues to be something that we need to do better on and integrate services across the spectrum after such incidents occurs. There were a number of executive orders administered and -- and I can point you to the website. All of these are available that really helped us in different times to relax rules and to get things needed where they were. For example, we were able to get health care workers

PHHPC - 12-6-2012 - Albany, New York

tetanus shots by other providers through one of the executive orders.

Medications and prescriptions continues to be one of the things that we don't always think about when pharmacies go down on a large scale, but we were able to work with C.V.S. and others to put mobile pharmacies up, to get primary care mobile vans out there to address the chronic med refills.

And while that was an initial surge in the E.R. visits, it's actually gone down to baseline levels, and we -- we are continuing to strengthen those systems.

Water testing, we don't think about it but it was a big part of the response and we had to continuously monitor sixty-two different water systems and see what was potable. There were no issues with boil water advisors that went out that have subsequently been resolved. But with sewage overflows, there were systems down because of generators not working. All of that has now gone back to baseline.

Other things you may not think

PHHPC - 12-6-2012 - Albany, New York

about, the Women Infants Children program, we had to relax rules and we sent out thousands of units of formula to the centers early on, so that there would be no interruption in the program and in the feeding of instants who receive care from the WIC program, and working with our federal partners to relax those rules.

I mentioned the vaccinations, the -- the Tdap shots and flu vaccine shots in real time. Waivers, we were able to work with C.M.S. on an Eleven Thirty-five waiver and we continue to work with them on an Eleven Fifteen waiver to meet the real short-term needs of facilities affected by the storm. Those conversations continue. And just a word about all of the waivers, there are three waivers -- three large waivers in front of C.M.S. right now under consideration. One is a -- the Medicaid redesign team waiver. A second is the D.D. waiver. And the third is the -- the waiver related to Sandy. All of those conversations are -- are actually progressing well. We had a conversation yesterday with C.M.S. We have more planned today and tomorrow. The -- the timing is

we're -- we're really working mostly on getting some smaller -- some final issues resolved with the D.D. waiver, after which we should be able to make real progress on all of them. I think that we have made real progress on all of them and I am optimistic that we will see significant progress by the end of this month on all three of them.

Additional funding was -- requests from FEMA and the Small Business Administration have also been started. We've had Governor Cuomo travel to Washington. He's requested forty-two billion dollars for New York's health recovery, and there is health care money in that forty-two billion as well beyond the waivers. There is mitigation money in there. There -- there are a lot of pots of money in play right now between FEMA, the Small Business Administration, the new appropriations, the Eleven Fifteen waiver, and we are working with all our partners to make sure that we have a unified message and that everyone is up to speed.

We're having calls with providers. We've had calls with every provider

PHHPC - 12-6-2012 - Albany, New York

group about what -- what they -- if they're nonprofits. What they can apply for with FEMA, if they're for profits what they can get from Small Business Administration, and we're working both within the state and with our federal partners to make sure that what happens after Katrina in New Orleans doesn't happen in New York, and that we actually do see our community and our health care community come back in full force and meet the needs, and in fact, come back stronger than before the storm.

Mobile vans have been deployed. We have one now today, I believe, in Long Beach Hospital's site, among others. And this has been actually a very strong partnership with F.Q.H.C. such as Rafua (phonetic spelling) who have really stepped up to the plate and gotten these resources mobilized out there in the community meeting needs in real time. We have data which we'll share at some point on all of the numbers of visits. This is a real success story as well.

Post-storm, certainly the cleanup continues. They should have shown me picking

PHHPC - 12-6-2012 - Albany, New York

something up there, but they didn't. There -- there's a lot to be done and I -- I assume that many of you have been out there. You know that there are continuing needs. Yeah. The disaster recovery centers, again, just to emphasize mental health needs was one of the things that we need to continue to strengthen and think about in response.

As you know, many large hospitals, including -- Long Beach is not on this list -- remain closed and we are working very closely with all of them, and we are hearing positive news on these fronts. N.Y.U. just got a -- a commitment for a hundred million dollars just a day or two ago. Bellevue, we're in close talks with them to open up and really be up and fully functioning within quarter one of -- of 2013. But we are monitoring the -- the beds and the remaining beds in Manhattan are -- are very full. And we continue to think creatively of what happens if we have a bad flu season or other second surge needs working closely with all of them.

Nursing homes and adult care facilities have been fully repatriated, fourteen

PHHPC - 12-6-2012 - Albany, New York

and twelve of them respectively. Obviously, there's a lot of work that needs to be done. I will leave you to the slide back to -- to look at Sandy. I want to turn to some other issues because there's a lot of -- of other things that I want to talk about, so let me switch gears here.

We did release our fifth annual report on hospital acquired infections last week. We made progress in a number of critical areas, things like forty-one percent relative decrease in the rate of CLABSI those central line associated bloodstream infections in New York, since the reporting began. So from 2007 through 2010 there's a forty-one percent decrease.

We see similar progress across many other fronts. The main benefit, obviously, is not just the patients do better with improved quality of care and reduced health care associated infections, but we've really learned from Don Burwick (phonetic spelling) and others that quality and cost live in the same dimension. And we've seen significant savings from shorter hospital stays.

PHHPC - 12-6-2012 - Albany, New York

Hospital associated infection rates have produced estimated savings of between twelve million to forty-eight million dollars for CLABSIs alone, and between nine point four million to twenty-seven point three million for lower surgical site infection rates. And those numbers continue and that report has a lot more data. I encourage you to go to the website to see the full report.

I -- I would also encourage you to go to the website, the Department of Health website and download the adult cardiac surgery report which has shown that in 2010 the in-hospital thirty-day mortality rate for cardiac bypass surgery was one point five eight percent. This is a decrease from the 2009 rate of one point seven nine percent. We continue to do well -- well lower or better than the national averages because of our tracking systems that we have, because of our registries. Similar statistics for the combined in-hospital thirty-day mortality rate for valve and combined valve bypass surgeries in 2010 was four point five nine percent, a decrease from five point

PHHPC - 12-6-2012 - Albany, New York

four five percent during the 2005-2007 reporting period. Again, the website has the full report.

Earlier this week, the Department of Health observed World AIDS Day and we hosted a two-day healthy living expo in Albany, raising awareness on H.I.V. and AIDS and reducing fear and stigma about the disease and encouraging young people to be engaged in efforts to reduce H.I.V. and AIDS. I want to thank everyone in our AIDS Institute for creating such an energetic and engaging event this year, and I hope that the message is heard across the state.

I want to talk a little about our progress on the exchange. We've made significant progress since the last update. We have, just last week, submitted a hundred and ninety million dollar multi-year level two grant, which will fund the exchange activities through January 2014. We've already received a hundred and eighty-three million, so this one hundred and ninety million is new dollars that we've requested. We hope to hear positively on this before the end of the year. We have now had -- we are estimating that running the

exchange will be on the level of about a hundred million dollars a year from 2015 onwards. And we are conducting a number of studies to see which savings can help cover and differ some of those costs. Those studies are underway. We are trying our best to avoid new user fees, but no decisions have been made on the sustainability plans. Those studies are underway.

Our early October meetings with the feds on the design review of the exchange led to a submission of a blueprint. That blueprint has been submitted and should be conditionally certified by the end of the year, so that's a big milestone for the Department. Once we have conditional certification, we're -- we're -- we're in the homestretch.

I will stop now to speak -- to address any questions of the Council. Oh, I'm sorry. I -- I would be remiss in myself also personally thanking Rick Cook. This is a difficult time to lose such valuable historical memory and a close personal friend. Rick was instrumental in getting me up to speed quickly and understanding

PHHPC - 12-6-2012 - Albany, New York

the scope of the body, the many changes that we've seen. He was the reason we've had a successful HEAL grant program, a successful C.O.N. redesign, a successful NYSCON release, among many other accomplishments. And it's with a twinge of personal sadness that I say goodbye. But I know that we will not say goodbye to you and we will find you working hard in some other field and contributing to the people of the state. So with that, I'd like to end -- end my report. Thank you, Rick.

DR. STRECK: Thank you, Commissioner. Are there any question -- any further questions about Rick Cook's accomplishments? Or are there questions for the Commissioner?

Dr. Bhat?

DR. BHAT: Commissioner Shah, you mention about dialysis. I think you're absolutely right. I think we did not lose even a single patient entire time. I think -- I have to commend the D.O.H. for taking the leadership because there was a coordinated effort between D.O.H., FEMA,

PHHPC - 12-6-2012 - Albany, New York

Greater New York. We had telephone conference calls couple of times a day for about three to four days up until we knew everything is going in the right direction.

Then what really helped us is what had happened with Katrina because a lot of stuff that was not done there, we were able to do, including my request of the governor to give us a waiver to recognize a system outside the state, which was -- it was given to us. So I think it's -- most of patients were dialyzed on Sunday because we knew, I think, because this is going to be a major major storm. Thank you very much for your support.

COMMISSIONER SHAH: Thank you. I think there's a book that needs to be written about what happened with dialysis and how it went right and how that -- those ongoing conversations that what were really all the partners around the table making it work, whether it was getting sterile water, whether it was making sure that FEMA generated the -- delivered the generators and fueled them in real time. There was incredible

PHHPC - 12-6-2012 - Albany, New York

coordination to make sure that that was a success and it was. Thank you.

DR. BHAT: And we learned a few other things for the next time because I think a lot of holes in -- all of us do have disaster plans, but those disaster plans were probably not adequate at all, so we are all preparing to have something like Sandy coming in, in the years to come. Thank you.

DR. SULLIVAN: Now I'm just coming from the H.H.C. system. I just also have to thank the Commissioner for the kind of coordination that happened throughout this disaster. I mean from big questions to little ones, because we ran a couple of the shelters, we often got the answer, the Commissioner said so and such, and such and such. And then we had the decision in our hands. And I can't tell you how important that kind of communication and that kind of, you know, rapid response is when you're on the ground in the middle of a disaster like this. And I think that that level of coordination really helped us all get through. And certainly, the support of our damaged

PHHPC - 12-6-2012 - Albany, New York

hospitals has been tremendous, and I think we're going to try and get them up and running as quickly as we can.

But I do think the communication system was essential and by and large, I mean, it went fairly well, considering the degree of damage that happened to our hospitals. I have to thank you personally because I know in our shelters in Queens, we sent a few questions up and we got responses, which I think is kind of remarkable in the midst of all that chaos we got those answers and we were able to kind of do good service in the shelters. Thank you.

COMMISSIONER SHAH: Well, it's a testament to the leadership of Allen Avelas (phonetic spelling) and Ross Wilson, who I think I spoke to about thirty times a day and actually they sat in that center that you saw with us. And -- and they are just emblematic. I mean, they -- they represented the leadership at all levels of H.H.C. from Coney Island to the front line staff of Bellevue. Every level, there was incredible leadership. Nothing but the good of patients was

PHHPC - 12-6-2012 - Albany, New York

considered. And we did whatever was necessary to ensure that. That's why it worked. And both Al and Ross should also be commended. Thank you.

MR. FASSLER: Just feel it's necessary to make a comment because of Sandy. During this time we were a receiving organization for evacuees and a matter of fact, the Department of Health wanted to set -- set up a adult care facility in seventy-two hours. And it just was truly amazing to see the leadership for Karen Westervelt, Laura LaFay (phonetic spelling) that we had to deal with regulatory issues, supplies, crazy, you know, crazy things going on, and they were there early, late, you know, through the weekend. We admitted two hundred patients in one day. And just to have Department of Health working together with an organization cooperatively and having positive impact upon, you know, patients was something just truly amazing. And, again, thank you for leadership and -- and for your staff.

COMMISSIONER SHAH: Well, it is Karen and Laura. You know, they -- there -- there was great personal sacrifice when -- when at all

PHHPC - 12-6-2012 - Albany, New York

levels of the Department and at the -- and among the providers. That's why it worked. I know that Karen and Laura, when they were in New York City in that -- the city OEM offices, I could actually sleep and comfortably.

And I think I slept for like two or three days because Karen didn't get a response from me, but -- but Karen and Laura were really instrumental in the front lines, making that happen on all different sectors, whether it's hospitals, nursing homes, adult homes, homecare. The scope -- at some point, I think, maybe in about twenty years I'll write a book because I do have a notebook with all of this somewhere. Thank you.

DR. BERLINER: Commissioner, given the amount of hospital capacity that's -- that's out of the system now, are we seeing any repercussions as a result of that?

COMMISSIONER SHAH: So there is a, you know, during the storm -- prior to the storm, we were at eighty-six percent hospital capacity. Immediately during and after the storm, we were at a hundred and three capacity. This was

PHHPC - 12-6-2012 - Albany, New York

in Manhattan. We continue to monitor those numbers with Greater New York and HANYS regularly. We are trying to be creative about understanding what is a real excess capacity versus, you know, you need this kind of excess capacity for preparedness.

Our -- our short-term and long-term needs differ. Short-term, we're looking for what would happen if we had a bad flu season. Long-term we're looking at what -- what are the right numbers. What is the right amount of beds that we need and -- and it's not really excess capacity, it's just capacity. And -- and that extends -- that conversation extends certainly to the nursing homes, but also all the way through home care.

All parts of the system are being examined to understand how do we need, what -- what are the numbers we need to make sure that there's some capacity and some resilience. That -- that's a really strong -- that's part of the conversation that's happening now.

DR. STRECK: Mr. Kraut?

MR. KRAUT: You know, two other

PHHPC - 12-6-2012 - Albany, New York

observations, one I'll share with you from a meeting yesterday. First is as -- as well as we did, we obviously there's a -- there's a lot of opportunities here, but one of the things that struck us is the health care workforce. And the fact that many of these people -- we had over two hundred and thirty people who lost their homes who are now not in them and they showed up for work. They left their families. They left their homes. They came and did what they had to do. And so as -- as a state, the health care workforce has -- you couldn't say enough wonderful, positive things about them.

The second is yesterday I was at a meeting with the O.E.M.s from Nassau and Suffolk. FEMA was there, Long Beach, the city management, the county management was there. And the observation was made that in the midst of all of this, the only place that was open for health care was the hospital emergency rooms. Ambulatory surgery centers weren't open. Primary care centers were not really. Doctor's offices weren't open. And to the point I think -- I think it was Dr.

PHHPC - 12-6-2012 - Albany, New York

Berliner made before about as we think about the future, let's not forget at the end of the day in an emergency, the one thing our communities count on is our hospitals. And it's the front door in the event of -- of tremendous disaster.

So as we -- we talk about inappropriate things and this and that, just remember there is an indispensable asset for our community is -- is these institutions and -- and the people that not necessarily lead them, but the people that staff them every day, so just pass that along.

DR. STRECK: Dr. Strange?

DR. STRANGE: Just to reiterate a little bit about what Mr. Kraut just said. We had, as you know, on Staten Island a large number, a big hit, and a number of those two hundred that Mr. Kraut just spoke about were -- were Staten Island workers who have been displaced to this day and still come to work every day.

But to Dr. Berliner's point about capacity, at one point in Staten Island we -- besides taking care of the acute care patients, we

PHHPC - 12-6-2012 - Albany, New York

were taking care of some sixty or so patients who were in need of their chronic disease management, oxygen therapy and the like, where they couldn't get it at home and couldn't get it in shelters.

And, again, thanks to your office, we were able to expand beds at one point, over bed capacity because there was no other choice and the other hospital in Staten Island was already filled. And those are some of the redundancies or grey areas that we need to look at in disaster plans where we may need to go over because it's not just the acute care needs, but it's the chronic care needs of the community where, as Mr. Kraut just said, we were the only place with lights and food and heat, and people were coming to us as shelters were either not accessible or were already overcrowded.

And we continue on Staten Island to have great challenges, as you know, with mold, as will be discussed, and the whole issue of immunizations and lost immunizations. One of the things we think should be learned again from this response and, again, to Mr. Kraut's point, as -- as

PHHPC - 12-6-2012 - Albany, New York

all of the physicians' offices in Staten Island were closed, all of them, one of the things that we thought about doing was opening up areas of the hospital to create primary care access other than the emergency room.

And it's something we should think about down the road, to utilize the hospital as office space, as I carry now my office on this computer as it's a fully electronic, I just did work sitting here a little while ago. So I have the ability to access patient records very easily. And my office is almost virtual now. So I can literally see patients anywhere with the records in front of me because it's in a cloud somewhere and you can come in and see me. So we had talked about -- and then fortunately enough a number of our physician's offices opened by the end of the week, about actually utilizing hospital space as primary care offices. But we -- I'm sure there are regulations and regulatory issues with that, so we need to think about that in case of the next disaster.

COMMISSIONER SHAH: I just want

PHHPC - 12-6-2012 - Albany, New York

to comment quickly. I think, you know, that that's a great set of questions that we need to answer. We have been and -- and thanks to the New York Academy of Medicine for hosting, along with the Institute of Medicine, soon after the storms a meeting, where we started talking about what are the data needs for recovery, and things like what are the risks and benefits of evacuation. What are the workforce needs when people are caring for their own families? Fuel? Certainly mandates for different types of facilities for buying generators or -- or fuel stations, frankly. What -- what is a minimum criteria set for repatriation? Which set of rules do you automatically relax during a storm, such as census counts, and there's certainly a complex system problem around fuel. Optimal use of social networks. There's -- there's a whole book of work that we are engaging upon, and we're not doing it alone. We're doing it with all sorts of partners at all different levels because what we learned is that once in a hundred year event, doesn't happen once in a one hundred years. And whatever it looks like, different parts of the

PHHPC - 12-6-2012 - Albany, New York

system need to be able to react and -- and recover.

DR. BOUTIN-FOSTER: Also as we consider and prepare for whether it's the next ten years or twenty years is also to understand how do we mobilize community networks because an elderly person who's in the hospital and in the nursing home, they're counted for. We know who they are. But someone who's homebound and they're relying on their community health work or V.N.S. and if that service cannot get to them, the person who knows best is, you know, the woman next door who can knock on her door, the man next door. So I think as we move forward to consider -- consider how do we mobilize community health workers faith based organization and build community capacity to respond before more structured services can come, so --.

DR. MARTIN: Just a -- a quick question. Obviously, I echo all of the commendable things. Thanks for the incredible amount of work that was done and -- and the effectiveness of it. You mentioned flu twice and from I heard the flu season may be off to a little bit of an early start

PHHPC - 12-6-2012 - Albany, New York

and the like.

I just get a little bit surprised about -- about the lack of -- of -- it just seems a wonderful opportunity to try to get vaccinations up now as a public service move and as a true -- virtually, an act of patriotism at this point to avoid the catastrophe that very well may come if we had a bad flu academic. I'm just curious if there's anything going on that I'm unaware of that's moving in that direction?

COMMISSIONER SHAH: Well, you know, right before the storm, one of the things that I talked about in various settings was health care worker immunizations and the deplorable state we are in, in the State of New York with an average rate of in -- in the mid-forties. These are people who are taking care of patients in hospital, nursing home, and other settings who are not getting their flu shots, or -- or they are and we're not capturing them. Let me be fair.

And I think that it's incumbent on all of us in every setting in health care to really provide patient centered care by getting flu

PHHPC - 12-6-2012 - Albany, New York

shots, by documenting them, and if there are reasons that someone who is in direct contact with patients is not getting a flu shot, they can wear a mask during patient contact for the duration of the flu season.

So I -- I think there are ways that we could get there. I -- I think it's incumbent on us to think about how we get there. I am averse to mandates because that leads to -- you know, it -- it doesn't lead to the culture of change that we really need to foster, but that -- that is an opportunity. And I think that we should really think together and I will go back and think about how we can get that message out stronger this year than any other year in the past at all levels because of the unique nature of the circumstances. So thank you very much.

DR. STRECK: Well, I think, Commissioner, that the comments from the group and others that have been made point out the appreciation for you and the Department and all involved in this. And I would just point out that through this extraordinary personal commitment on

PHHPC - 12-6-2012 - Albany, New York

your part, on the part of all individuals, the sleepless nights and everything else, you've accomplished something rarely accomplished by a commissioner in New York State and that is that you met expectations. So it's quite an accomplishment and an impressive presentation.

Okay. We'll move on now to the Office of Health Systems report. Ms. Westervelt?

MS. WESTERVELT: In deference to the committee's time, I'm going to make -- I'm not going to make a formal report. I just want to echo the Commissioner's sentiments and thank our health care provider community. We could not have done what we did without the support of our provider community pre- and post-storm. It was just incredible, and many, many people sitting around this table as well putting up with the two thirty a.m. phone calls and et cetera, so I wore out my welcome I think in the first month of the new job.

So -- so that's what I also want to just echo the Commissioner and this -- the membership sentiments about Rick Cook. It is a sad day to have Rick actually leaving. And I think

PHHPC - 12-6-2012 - Albany, New York

Rick had said to me when I first agreed to take on this assignment that it was going to be baptism by fire. What he didn't tell me it was going to be like learning how to dance with -- with Fred Astaire, but I would be Ginger Rogers dancing backwards in high heels, so --.

But I very much respect his counsel and he's been so, so tremendously gracious and professional during this transition. It's been phenomenal and I'm looking forward to hopefully being able to continue that relationship with having him as a colleague in his new role. And we wish him the best moving forward. Thank you.

DR. STRECK: Questions for Ms. Westervelt?

We'll move on then to the Ms. Block's reports. Slides. Okay.

MS. BLOCK: Thank you. I also will be brief. I've been updating the Council at all of your meetings on the current status of meaningful use dollars coming into New York State. We're now up to, at the national level, a little bit over eight billion dollars, and in New York

PHHPC - 12-6-2012 - Albany, New York

State just hovering under five hundred million. And chances are before we get to the end of this year, we will meet or exceed that number.

You will also recall that we accepted a challenge from the federal government to get nine thousand eligible professionals to meaningful use. And at this point, and this is just through the end of November and -- and the end of October for Medicare, we're just about at that nine thousand number, so we -- we will, in fact, exceed the number that we accepted as part of that federal challenge. So we continue to be extremely proud at the very hard work that hospitals, physicians, and others have undertaken to reach this goal.

On a little bit more of a once the immediate issues associated with the disaster have gotten a little bit settled down, we wanted to undertake a little bit of a review of -- we're obviously now increasingly relying on health information technology as a key component to health care delivery. And we wanted to assess how is health I.T. specifically implicated in terms of

PHHPC - 12-6-2012 - Albany, New York

disasters and disaster response?

And there are just three quick areas that I wanted to touch on. Obviously, the first health care operation. Several references have been made now to the extent to which emergency preparedness plans were -- were sufficient and actually road tested. Maintenance of patient records, this is not a new issue but again, in the electronic world the good news is if you got yourself in the Cloud you should be able to get access to it, but if you don't we have to figure out how we're going to deal with those issues in the future.

Data backup and disaster recovery, you know, for -- for better or worse, the choice of many I.T. companies to have their telecommunications in lower Manhattan, we ran into this in one earlier incident and obviously that -- that affected operations as well, so we probably need to be looking at a little broader geographic distribution of certain backup services.

Business continuity plans, many of these things are actually requirements under the

PHHPC - 12-6-2012 - Albany, New York

HIPAA security rules. It's been a while since we dusted it off to take a look at that, but we will be doing a more comprehensive evaluation working closely with all of the provider associations. And I think that probably the most striking aspect of this which was referenced in the immediate response is the fact that many of the community based providers adult care facilities, other providers that are providing home and community based services, the very purpose of which is to ensure that elderly and disabled people can live safely at home aren't really connected at this point to these electronic capabilities that -- that we are establishing. And so we need to really, I think, come up with a -- an effective and efficient way to try to get them connected in the future.

We had a lot of questions about policies governing access to and the use of personal health information. Obviously, there is complex laws and regulations associated with all of this, but to the extent that RHIOs were able to provide information that would be useful, we had a lot of providers who don't necessarily have

PHHPC - 12-6-2012 - Albany, New York

agreements in place to access that information.

We talked a little about setting up a quick attestation basis for providers to get access to information if they aren't currently enrolled. We tend to use breaking the glass for clinical emergencies and I think we're called upon to see if we should be falling back on that as a way to get access to information into other types of emergencies. I think we don't really think that's the right way to do it, that we need to be defining other mechanisms that would be appropriate for other types of emergencies.

Getting remote access to systems from alternate sites and setting up policies and procedures for that, public health access which is a general topic that we've been working on obviously becomes even more critical under these circumstances. And, again, I think the important experience from this, a lot of nonclinical users who need to have access to some level of information and coming up with some effective policies access by who and to what that would be appropriate to maintaining protections, but also to

facilitating access to key pieces of information.

And along those lines, one of the things that this brought back to the forefront are some ongoing discussions that we've been having about creating better ways to set up patient tracking databases. On the current state we have the ability to do this, but it's still mostly a manual process, and that is dependent on both access to the Internet and some other things. So we set up a system that was appropriate to the capabilities that we currently have. And -- and as the Commissioner said, I think that we feel like we -- we kept track of everybody and we were able to find them again and -- and that's a good thing.

But clearly, these are not as streamlined or as robust as they could be, so we are now exploring the questions of how we could leverage health information technology and the statewide health information network in the future. And just among other things, the ability to quickly comb admissions, discharge data, and master patient data for identification and tracking purposes.

Access to clinical information in

PHHPC - 12-6-2012 - Albany, New York

other sites which was obviously a -- a key use case under this circumstances. I mentioned the additional personnel and types of access that we need to be thinking about and increased participation in the SHIN-NY in some form among the community based providers.

So those were the slightly longer-term issues that we'll be working on. And I'm happy to take any questions. But even more important, if there are any members of the Council who are interested in working with us on these things, I would be happy to hear from you and set up some further conversations. Thank you.

DR. STRECK: Questions? I -- I have one just in terms of resources. You have a fairly full agenda before dealing with planning for the next emergency. And I'm -- are -- is your plan to do this through task forces? Staff? I'm just curious where this fits in a already pretty loaded agenda?

MS. BLOCK: Well, fortunately, as I think you know, we have our partnership with the New York eHealth Collaborative, which really helps

PHHPC - 12-6-2012 - Albany, New York

us in a couple of important ways. They have staffing which are dedicated to many of the technical operations as well as policy functions that are necessary, and we can essentially fold this -- these issues into some existing work streams and prioritize them accordingly.

And I think that what all this does is basically take some things that we would have done otherwise and kick up some prioritization of certain things. So, for example, our policy committee which has had an ongoing review of privacy and security policies will be able to accelerate their review of some of those policy issues that I mentioned.

So I think we have the basic capabilities, organizational structures, and -- and resources in place. And the infrastructure is built in such a way that it is very leveragable. So I think that within the current resources that we have, we can utilize the existing infrastructure. And I think where some of the things that we'll need to look at and -- and be very creative about is particularly that issue

PHHPC - 12-6-2012 - Albany, New York

about connecting community based providers in a more ubiquitous way and -- and make that as cost effective as possible in terms of how that would work.

So I think that's the one area where we probably need to explore a bit further. But I think the existing governance and technology infrastructure that we built is sufficient to address many of the issues that I've identified.

DR. STRECK: Other questions? Comments? Thank you very much.

So turn to the Office of Public Health, Dr. Birkhead?

DR. BIRKHEAD: Thanks very much. I'll quickly just pick up on one aspect of the Sandy response which is still ongoing even -- even six weeks into this. And that is the concern about respiratory health in areas impacted by the storm. And there have been news -- news stories about this recently.

Just to let you know what's happening in -- in the -- in the realm of public health sort of below the radar, there are two

PHHPC - 12-6-2012 - Albany, New York

surveillance systems that we rely on to monitor this. One is our syndromic surveillance system which captures on a daily basis emergency department visits. And we've been tracking those for both respiratory symptoms and asthma. And we did see a small bump immediately following the storm, but has -- has returned back to baseline. In fact, at the moment the highest area of the state is in the Upstate New York, Central New York area, where flu has gotten a head start on everything else, so at -- at least in the areas of New York City and Long Island, lower -- lower Hudson where the storm hit we have -- we have no seen that.

We also had temporary surveillance going with federally qualified health center vans that went in on a daily basis and reported back what they were seeing.

The second surveillance system which we -- we track are D.E.C., Department of Environmental Conservation air monitoring stations, which are set up and -- and operate and provide daily information as well. And we have not seen

PHHPC - 12-6-2012 - Albany, New York

what they characterize as any new air quality problems. Obviously, in a large urban area you will sometimes see air quality problems from traffic ozone and other things, but those monitoring stations have not seen a problem.

So -- so what -- what could be -- else -- else could be going on with respiratory illness? I think obviously we still want to get the message out to people who are working on renovating or -- or fixing up their homes, worksites, or actually trying to live -- live in a home without full services, without full heat.

Obviously, you need to take precautions against dust and mold and other -- other things that may be present in the environment. Wear a mask, take other precautions while you're working there. And if you're living in a home without heat, the cold temperatures obviously can also lead to respiratory complaints. And so -- so people should just take that into consideration, and if they have underlying respiratory illness may want to find some place to go to warm up every day or -- or find -- not -- not

PHHPC - 12-6-2012 - Albany, New York

try to stick it out while repairs are -- are being carried out.

It's been mentioned that we're in an early flu season. We're also into the winter, which is respiratory virus season, so those -- those baseline sorts of things are also going on. Part of this, I think, is getting word out to people who are in the affected areas. Communication still may not be good there. We've put out and the City Health Department alerts in the last couple of days to the health providers, pretty broadly to give them information and also to have them share that information with their patients.

And at your desks is a copy of a -- of a respiratory concerns and mold cleanup fact sheet with links on it that we are asking providers to hand out. And these fact -- this fact sheet will also be sent out through our network of contracted -- contractors through the AIDS Institute, through our nutrition contractors, our other family health contractors, as many different outlets as we can find for them. And these -- this

PHHPC - 12-6-2012 - Albany, New York

document will be on the website. So if your organization wants to also, if -- if you're in the affected areas, hand this out to clients living in affected housing, that would be great. So part of this is communication getting -- giving people information and I think it's safe to say that the full communications haven't yet been restored in some of these areas, so any help we can get would be -- would be gratefully accepted.

I think that's it, just an update on where we are and -- and the response is, as Dr. Shah said, continuing. Usually at some point we get pretty much into recovery, but we're still, I think, in the process of responding to some aspects like the respiratory issues.

DR. STRECK: Dr. Strange?

DR. STRANGE: Dr. Birkhead, thank you very much. And I think that it's wonderful and the education on this just continues to be move -- need to be moved forward. Two things to be learned, though, from Katrina and other disasters that are -- that will become other public health issues which has been reported in JAMA and other

PHHPC - 12-6-2012 - Albany, New York

journals is that somewhere around three to six months post any of these disasters, and Katrina specifically, the incidence of cardiac disease, specifically accurate M.I.s, triple to five times the amount -- five times the incidence in these disaster areas for multiple reasons, the stress, people not taking their medications, lack of coordination of their care again, either because of not access or there are more important things to do.

And then on Staten Island specifically we're seeing this, but I'm sure it's in any other area, the cycle social issues, especially in the time of the holiday season when depression is increased anyway. We on Staten Island don't have any adolescent childhood psychiatry services to begin with, and we are going to see the increased uptake of that. I think we've already started to see that. And so I think we should keep our eye and focus on those two areas. I don't know how specifically, you know, we can deal with it other than to just alert our practitioners and hospitals that this may arise.

PHHPC - 12-6-2012 - Albany, New York

I'm really particularly concerned about the psychosocial stuff, depression, exacerbations of schizophrenia, bipolar disorder and so on. These are two other public health areas that I think we should -- we should keep our eye on.

DR. STRECK: Gus, I have a quick question. The note points out that you shouldn't waste your money on testing for mold. Are there a lot of testing groups out there offering services? I mean, and is there a -- a way to deal with that question or has that become an issue? I'm just curious.

DR. BIRKHEAD: I don't know how many groups. There -- there are certainly environmental labs out there that will -- that will do testing. I -- I don't know how big a problem that is.

COMMISSIONER SHAH: Yeah, there have been actually a -- a number of scams. And I believe the governor, in a recent press release in the last week or two, identified the types of scams that have come out, this being one of them around response.

PHHPC - 12-6-2012 - Albany, New York

DR. STRECK: Other questions for Dr. Birkhead? Thank you.

Okay. We'll now move to Public Health Services and Dr. Boufford will give us a major presentation on the New York State's Health Improvement Plan, the prevention agenda, and I believe this is the product. Am I correct? This is -- this is the product that has been under development?

DR. BOUFFORD: It is -- it is indeed the product, yes.

DR. STRECK: Okay. Jo?

DR. BOUFFORD: Could you -- could that just switch around so I can see it because otherwise I'm going to get a bad crick in my neck. Thank you very much. I have the clicker which I think will work. Thank you, Commissioner.

Well, good morning, everybody. I -- it's my great pleasure to present to you the prevention agenda, 2013-2017, which is the New York State Health Improvement Plan. It has been, it is a creature of this Council at the request of the State Health Department, so the Public Health

PHHPC - 12-6-2012 - Albany, New York

Committee has been working very hard over the last six months or so with really unprecedented collaboration across the state.

We've had over a hundred and forty organizations involved and multiple community engagements as well on this report, and really gone beyond traditional stakeholders, so this is beyond local health departments and health care providers and payers. We have included health plans, community based organizations, advocacy groups, academia, employers as well as other state agencies like education, agriculture, transportation, criminal justice, and others that aren't normally involved. And we're hoping those relationships will be a basis for building future collaborations.

The plan is really designed with the reality that it only gets implemented at local level and local communities, so the objectives and the interventions and the metrics are really designed with that in mind. And we're hoping, as part of the communication rollout, to -- to really be able to provide support for local communities, multiple stakeholders as they take this on.

PHHPC - 12-6-2012 - Albany, New York

We did create an ad hoc committee to lead the prevention agenda. This is one of the requirements of the state accreditation process that there be a multi stakeholder sort of if you will public private partnership involved. These are the organizations that were represented. I believe this is most of them. We had people joining us periodically from time to time and staying with the process.

We -- this group met three times over the last year and as recently as November 16th in the face of all the things we've been hearing about this morning, convened almost in full in four locations around the state to review the final draft of the plan. And this then was brought to the Public Health Committee on the 19th. Six of our Public Health Committee members were actively involved at each state, Dr. Boutin-Foster, Dr. Gutierrez, Ms. Hines, Ms. Rautenberg, and Dr. Yang. So we thank them for their ongoing engagement.

Just to review the big picture of the -- the agenda before get through, we've seen a little -- few of these things before, but it's been

PHHPC - 12-6-2012 - Albany, New York

a while. So the vision of the report is that New York is the healthiest state. We're now ranked eighteenth in the United Health Fund state rankings and we want to improve that -- that ranking. And we got into a conversation about how we do that as we go through in terms of the metrics that are being used.

We also wanted to define the actors in this very broadly. We -- I just mentioned the issue that a community based engagement is important and we borrowed this diagram from the Institute of Medicine. As always with New York, we modified it so that we beefed up some of the elements in the health care delivery system, which, as we've heard and we know, is a very critical part of the -- the overall health sector and the public health system in New York. And the message here is that you've got to get all these actors really sharing an agenda and aligning their actions to get the health result that you want to get at the state and local level. And that includes all the folks in this -- in this bubble diagram.

PHHPC - 12-6-2012 - Albany, New York

The goals of the report are as follows. There are five major goals. This is the one that has really, I would say, dominated our thinking during all of our development, which is that this is about priority areas for all of the -- of all people in New York and that includes especially attention to health disparities among racial, ethnic, socioeconomic, and other minorities especially individuals -- disabilities, this has been a strong theme of our work. One of the things that's really important is that you can -- there's the old saying, you lift all boats but you can do that but you may, in fact, increase disparity. So you have to pay attention to the interventions. You have to pay attention to the way in which you go about it because we have this dual goal really at all times.

Second goal is the notion of health in all policies. That bubble diagram I showed you is really an example that all of the stakeholders who can create health at the local level and the state level really need to think about the health impact of what they do. That may

PHHPC - 12-6-2012 - Albany, New York

not be the first thing they think about, but decisions that get made in transportation policy, in environment, in education, and agriculture, all have health impacts. And so part of this process is a broader educational effort and are really engagement with our colleagues and other sectors including the business sector and others to -- to really work with us on -- on advancing the agenda.

We also have the goal of dealing with governmental and nongovernmental infrastructure. We want to achieve these changes in health, but we want to leave the partners stronger on the ground at local level and the partnership stronger at the state level, so again, to impact these broader determinants of health, these -- these -- the process of these partnerships and the engagement has been a very important consideration for us.

We also -- I mentioned this is sort of an enhancement of the infrastructure issue. I think one thing I should mention on the infrastructure is the broader public health infrastructure really does include this Department

PHHPC - 12-6-2012 - Albany, New York

as well as our colleagues in OASIS and -- and -- and the disabilities agencies in mental health, and they are into really involved in this along with other agencies.

The fifth goal is something that we are aware of that we still need to make the case for why prevention and why public health action is important. I think with this in an era of super focus on bending the cost curve in the health care system, we think there's an enormous amount that can be contributed here, but the case is not made in a way that has convinced everyone. There's very good data on return on investment in community based prevention that could save several billion dollars in the state of New York in Medicaid, Medicare, and private insurance costs, on tobacco, exercise, and diet -- in our lifetime, not in ten, fifteen years, but in two to five years. And these are things that elected officials can begin to pay attention to because it could happen on their watch and that's exciting. And the more evidence we have in this arena the better off we are.

But for our investment in the

PHHPC - 12-6-2012 - Albany, New York

United States, we are over ninety percent of all money in the health system is in the personal care system whereas more than about ten -- fifteen percent of avoidable mortality is really related to health care. So we're very -- we have a very out-of-balance portfolio, and as a result as a nation we don't do terribly well when looking at our overall rankings on infant mortality and life expectancy for the money that we invest.

We're very aware of context during the course of the development of this plan. We looked at what was accomplished, the last four-year agenda, what went in the right direction and the wrong direction or didn't move. We looked very clearly at what our current health status is in the state and that was important in deciding which of the priority areas we would work on.

We were informed by national and state health care reform efforts and obviously the continuing weak funding environment for public health which is a national tradition and we hope in New York State with the waiver it will be changed and -- and can really add enormous value to the

PHHPC - 12-6-2012 - Albany, New York

overall public health agenda. And we've also put a lot of effort into linking with the M.R.T. waiver, the health planning activities, and C.O.N. activities of our colleagues in the Health Planning Committee.

This is a diagram that sort of lays out how health improvement is produced. You saw that various actors that have to be involved. And the reasons for that is that health -- we really start out in the middle of this circle being born with a number of characteristics, especially age and race and ethnicity and sort of D.N.A., if you will, genetic component that can't be changed or we're learning to change some of them later but they're basically unchangeable.

And then the individual effects of lifestyle, of family, of community, and then as we move into the built-in natural environment and the policy arena, all of these areas affect people's ability to be healthy. And so one of our goals is to come up with multifaceted change strategies that really can address and create healthy communities and health conditions through

PHHPC - 12-6-2012 - Albany, New York

intervention in all of these -- at all of these levels.

And you see that mirrored in this diagram. This was really guidance given to all of those working in the -- in the priorities we identified. This is a so-called framework for improving health of the C.D.C. pyramid that has been developed under Tom Frieden's leadership. And if you start at the top, it speaks to the kind of interventions that are quite individual in terms of personal counseling and education. You move down into clinical interventions, which can be broader based, especially if you're managing populations of people with diabetes or kidney disease or others. And then we move into some of these other areas that you saw in the other diagram, which is essentially long lasting interventions that really change the environment in which people live. So the availability of healthy foods, the availability of walkable spaces, the healthy housing, and -- and other areas that really allow the healthy choice to be the easy choice. And this is especially important in poor communities where people may know

PHHPC - 12-6-2012 - Albany, New York

what the right thing is to do but they can't -- they can't do it because they don't have the environment in which they can take advantage of it or they don't have the resources to take advantage of it.

So we're literally looking at creating strategies at every level. And every one of the plans that has been created for the five priority areas reflects activities in all of these areas. And I think one of the things we learn from this exercise is that start thinking prevention is new in a lot of ways. And I think many of -- this was a very interesting conversation especially in the substance abuse area that people have been so focused on treatment.

And the issue of sort of saying these -- we're looking for strategies that really focus on prevention especially population based prevention and working in communities is a -- a new way of thinking for a lot of people and partially I think we are always driven by where the resources are. So part of the task here is to see how, again, we can balance the portfolio of investment

PHHPC - 12-6-2012 - Albany, New York

to intervene at each of these levels.

These are the new priority areas that were identified. As I mentioned previously, I think the ad hoc leadership group, while we're guided by our expert colleagues in the Department, they did make a couple changes in the original wording of these five goals, and I want to just bring those to your attention.

In the second one, the word safe was added because the feeling is, again, in many communities unless the environment is safe, people cannot get the exercise they need, they won't go out, they won't engage in the kind of social connectedness and community building that they should be, and then obviously things like accidents and -- and trauma and abuse are important environmental issues. They also, instead of having only health mothers, infants, and children, they also put in healthy women with the goal of focusing on women as other than their reproductive function. And then the -- in the final one, health care-associated infections were added because it has been a major priority of the Department and it

PHHPC - 12-6-2012 - Albany, New York

is a nice link between public health and the health care delivery system.

So a wide ranging set of consultations, a set of very detailed slides that was made available. Over forty-five consultations took place, many led by members of the ad hoc group, and all of that feedback was brought together in the development of the final -- the final proposals, over two hundred people across these working groups. These included, again, many of these multiple sectors. Each group had its own working group or committee that met throughout the summer, and staffed by the health department. Each one is co-chaired by a -- a government, health department, or OASIS or mental hygiene senior official from the Department, and a private sector individual. So in the case of chronic diseases, our colleague from I.B.M. co-chaired that group. Ellen Rautenberg from this group and individuals from other academic institutions co-chaired -- in their private sector hats co-chaired women's and children's health and other examples like that. So there is a balance of public-private chairmanship

PHHPC - 12-6-2012 - Albany, New York

and participation in each of the working groups.

Each of them was given a template for developing their recommendations which included identifying the focus areas they would work with, the goals that they would select, measurable objectives and interventions along the health pyramid that I outlined, as well as the specific roles that each of these stakeholders should play. So there were suggestions for what could the business community do in one of the priority areas. What could academia do? What could the media do? What could community based organizations do?

We also had a steering committee that had virtual calls throughout the summer which consisted of the co-chairs of each of the five working groups plus additional individuals, especially from the N.G.O. disabilities community as well as some of our other agency colleagues to avoid unnecessary redundancy and to assure that we were coordinated in terms of where the pieces, we weren't contradicting each other in terms of our goals and -- and our objectives and interventions.

The -- it sort of happily at the

beginning of the summer we were able to get a grant from the Robert Wood Johnson Foundation which allowed a competitive process and the Rabin Martin firm was selected to work essentially as an -- as a partner in staffing each of the working groups and has continued to work with -- with the Health Department staff in the steering committee's activities and in this final production of the document through the -- the work of the working groups and the ad hoc leadership group.

Just to reiterate, again, the cross cutting principles that were also guidance for each of these working groups, again, the broader determinants have -- of health are essential so there are objectives and interventions in each of these priority areas that really are not in the control of the Health Department. They really involve, in some instances, other agencies or other actors, and so that is very important that we get in the habit of doing that, and that we're able to hold ourselves accountable as community partners.

Disparities, again, front and

PHHPC - 12-6-2012 - Albany, New York

center in all of our deliberations and keeping in mind the openings that we have in the M.R.T. waiver agenda with things like supportive housing, fluoridation of water, and home visiting and other areas that are complimentary to the agenda. Thanks to the work of Karen Lipson and John Rugge, we are very excited about the degree to which the State Health Improvement Plan is referenced to both in the regional planning documents and the C.O.N. process, and we really think that will be very important for promoting collaboration at the community level.

We do want to be sure that the most affected communities, again, those with the highest disease burden and at highest risk, are at the table at local level in the implementation process. And I'll speak to that after we go through the -- the review with you. And then -- then maintaining this collaborative process and strengthening both the governmental and nongovernmental entities that really have to deliver the -- the health result on the ground, and especially our colleagues in the personal health

PHHPC - 12-6-2012 - Albany, New York

care delivery system.

So with that, I'll turn it over to Gus to give you the sort of technical run-through.

DR. BIRKHEAD: Thanks, Dr. Boufford.

I'm going to quickly go through just the materials that are -- have been available to you to review, talk a little bit about how the objectives were set, the indicators selected, and the interventions selected to just give you a flavor of how this process is -- is structured, and then quickly go through each of the -- the primary goal areas.

The materials were posted last week on the Department's website in draft form. There's a summary document which, if you read nothing else, I think is very helpful to -- to understand what the process has been about and summarizes a lot of what Dr. Boufford just went through. And then we -- we lay out the five priority areas, and within those priority areas, focus areas, goals, and objectives. And the

PHHPC - 12-6-2012 - Albany, New York

specific plans with goals and objectives, we link to the pyramid, the C.D.C. health impact pyramid, we actually thought through each level of that pyramid for each of our goals what could be done there and which sector would be responsible for it. So to my knowledge, this is really the first time anyone has explicitly tried to go through and do that in the context of a statewide health improvement plan.

So the first step was setting objectives within our -- our priority areas. As you'll see, we ended up with fifty-eight objectives that we will track annually and post on the Department's website in a -- a dashboard type of format. And thirty-one of those objectives had a disparity or -- or high-risk population aspect to it. So the objective related to decreasing health disparities.

Most of the data are available at the county level, not just the state level. And, again, a very important part of this is to prompt county level planning by county health departments and hospitals. So we in selecting objectives, we

PHHPC - 12-6-2012 - Albany, New York

tried to select as many as we could where we had county level data so we can track that.

We also have four objectives that relate to health care plan or health plan data or objectives that we can track at the plan level. And we have two objectives that we're able to track at the hospital level. So as you'll see, if you look through, there are a -- a variety of types of objectives here and we tried to really cover -- cover all the bases.

This is a five-year process of the -- of the state health improvement plan, so we set objectives for a five-year time frame, so by 2017, essentially, since this is going to begin the beginning of 2013. And on average I think we came -- we -- we -- we -- it's always a challenge to pick what the target is, how much are you going to improve something, how much are -- are you going to reduce something. On average, I think these worked out to be about ten percent. For most of them as you'll see, though, we -- we actually had a little methodology and some ended up being more or -- more or less a ten percent.

PHHPC - 12-6-2012 - Albany, New York

In general -- there's a national set of objectives called the Health People 2020. In general, I think our goals are more ambitious than what's laid out by the federal government for objectives by 2020. We do have seven goals where we think it's important to try to measure, but we don't have exactly the data that we want to measure yet, so it's -- it's still to be determined how we will track those. But I think we're -- we're trying to expand our view and not just deal with the data we have at hand, but see if we can get better data to -- to -- to monitor what's going on.

In setting these objectives, we looked at each one in terms of the historical data that were available and the trend over time. And so if -- if the trend was of something was moving in a desirable direction, then we projected an improvement on the higher end of five to ten percent whereas if the trend on -- on something was moving in the wrong direction we were a little bit more sober, I think, in -- in picking a somewhat smaller percent improvement. But, in general, these are stretch objectives. These -- these are

designed to sort of push -- push us to do more, and in that sense are also aspirational.

We did have some objectives that were the same as the Healthy People 2020 objective and that's helpful to be able to track ourselves versus the -- the rest of the nation. But those goals were for 2020. In those cases, we -- we set that goal but at -- to 2017. So, again, we tried to push ourselves to be stronger than the -- than other objectives that are -- that are out there.

Here's -- here's an example of a goal area, how we -- how we structured them, in this case in the maternal child health area. The overall goal was to reduce premature births in the state, and then we had -- we set specific objectives, for example, to reduce adolescent pregnancy rates by ten percent. So adolescent pregnancy is an example of a measure that is -- is going down on its own, so we selected a higher -- I think a higher goal in this case for women fifteen to seventeen and other objective. You can see we've listed the data source here. And we've also listed the -- the Healthy People 2020 objective

PHHPC - 12-6-2012 - Albany, New York

for -- for reference.

And then this is an example where there is a large racial ethnic disparity, and so we set -- also set objectives related to reducing that disparity, so reducing the ratio of pregnancies among women fifteen to seventeen for -- for black, non-Hispanics to white non-Hispanics, reduce it down to a level of four point nine as a ratio. So you can see that there's a huge disparity there from the -- from the current five point -- essentially five point five level. And then another -- reducing the ratio of pregnancy for Hispanics to -- non-Hispanic whites, so we have a measure for both black and -- and Hispanic here.

So in general, as you look through, you'll see this -- this is the structure that's common for all of the -- all of the objectives. Just a little bit about -- again, about how selected indicators or where -- where -- where these -- these came from, a lot of these came from a document from the surgeon general's office called the National Prevention Strategy. There's also another document from the University of

PHHPC - 12-6-2012 - Albany, New York

Wisconsin, I think funded by R.W.J. that is county -- rankings at a county level. There're a series of measures there. There's another process that produces America's health rankings. These are things you can look up on the web and see where they are. The Health People 2020 goals, C.D.C. goals, and then -- and then our own internal goals. We did make an effort to align these goals and objectives with the M.R.T. process as well as a process that's enfolding -- unfolding across state government to develop -- each department developing goals and dashboard items. So rather than have a variety of different measures, depending on where you look for health in the New York, we have tried to align them as much as possible across all of these different initiatives that are underway.

We -- we do -- it -- did try to choose indicators where, again, we had county level data available, also race and ethnicity data which are available in most data sets but are not always of good quality. And one of the M.R.T. initiatives that we're working on are -- is to improve the quality of data collection in vital statistics in

PHHPC - 12-6-2012 - Albany, New York

SPARCS and other areas around even something as simple as race and ethnicity.

We also have databases that have disability and socioeconomic status in them, particularly our behavioral risk factor surveillance, which is a telephone survey, collects information about disability and socioeconomic status. So we -- where we had those data available, we tried to select indicators to focus on them, again, because the disparities issue not just with race, ethnicity, but also with disability and socioeconomic status are -- are so important.

And then as you saw in the previous slide, the -- we often looked at the disparity measure as a ratio or a difference between different populations of interest and then tried to set the objectives in -- in that way.

So those -- those are the objectives and how we selected them. We then moved on to look at the interventions that would be listed. And it -- and this is not a prescriptive set of interventions, you must do this. But these are -- these are things that in surveying the

PHHPC - 12-6-2012 - Albany, New York

literature at -- that's out there that are evidence based, that was one of our primary things we would like to bring to the attention of county health departments, hospitals, and all the partners at the local level that were working on this -- these problems, the -- the evidence base that's out there. And I think that -- providing that kind of technical assistance is very important and we built that into the plan in trying to identify selected interventions that have an evidence base.

That's the highest -- highest quality. There also are some which are promising practices or, you know, next policies, things that sound good. The evidence may not be quite there, but it's something worth considering again at the -- at the local level and -- and -- and best practices. So -- so trying to lay out what we know about what people are trying to -- to -- to bend the curve on these different measures and where there's evidence highlight that. Again, not being prescriptive you should, you must do this or that, but saying here's -- here's the best information that we have about these issues and how to address

PHHPC - 12-6-2012 - Albany, New York

them.

The -- the work -- the work groups, the committees, again, was a -- was a huge effort and -- and these measures and interventions were basically finalized by the working committees after assessing all of the potential information that we had out there. And I would say that this set of suggested interventions serves as a starting point. It's anticipated as we get more into this and engaged in more partnerships and more literature comes out that we will try to keep this updated throughout the course of the five years of the prevention agenda as new information is learned. We will make that available.

Part of this whole process is to have people try things and learn from each other and, where there's best practice or evidence identified, to try and go forward. So our -- our commitment from the health department is to really keep this a living process and to learn from what we're doing, not just wait five years and -- and then see what happens.

So I'm quickly going to go

PHHPC - 12-6-2012 - Albany, New York

through the five priority areas. We had within those five priorities eighteen focus areas. And on this slide is the prevent chronic disease priority area, and we had three focus areas which you can see on the left -- left-hand side. The -- the three focus areas in chronic disease were to reduce obesity in children and -- and adults. And you can see the kinds of goals that we established. Then these -- these link, I think, to the kinds of interventions, but create community environments that promote and support healthy food and beverage choices and physical activity, prevent childhood obesity through early childcare and -- and school settings, so the -- the different environmental settings where people may live and work and play, expand the role of health care and health service providers and insurers in obesity prevention, and expand the role of private -- public and private employers in obesity prevention. So we -- we've taken it to that level. Then you -- if you track through the plan that will then relate to a set of objectives and a set of suggested interventions around those areas.

PHHPC - 12-6-2012 - Albany, New York

Reduce the second -- yeah, too much detail. I -- I wanted to do --. Reduce illness and disability and death related to tobacco and second hand smoke. Tobacco does remain the -- the leading cause of preventable mortality in the state. So that need -- needs to be an area to focus on. And then increase the access to high quality chronic disease preventive care and management in both clinical and community settings.

Very quickly, the healthy environment was the second priority area. We had four focus areas within that, injuries, violence, and occupational health, air quality, the built environment and water quality. You'll note in here that climate change is -- is highlighted to improve design and maintenance of the built environment, to anticipate and adapt to climate change as -- as one of the things to -- to focus on. So I -- I won't go, again, through these in -- in detail.

The third priority area was promote healthy women, infants, and children. You've already seen one of the -- one of the focuses there on child health. But maternal and

PHHPC - 12-6-2012 - Albany, New York

infant health, child health and preconception and reproductive health are the focuses here.

The fourth area was promote mental health and substance abuse and we had three sub areas there, promote mental, emotional, and behavioral health, prevent substance abuse and other mental health disorders, and strengthen infrastructure across the -- the systems. Again, I think Dr. Boufford mentioned this was the first time we had fully engaged with our sister state agencies around substance abuse and mental health and it was a great process. And the focus really on prevention I think was -- helped them expand, as well, their thinking, again, on these things.

And then the final area is the -- essentially the preventable infectious diseases. Vaccine preventable disease, H.I.V., sexually transmitted diseases and hepatitis, and then health care associated infections. And you can -- you can see the kinds of goals that we've laid out here.

So I'll turn it back over to Dr. Boufford. I just want to say and -- and at this point acknowledge and thank her for her leadership

PHHPC - 12-6-2012 - Albany, New York

in this process. I don't think we would be anywhere near where we are now without her in -- daily involvement. And also thank Sylvia Pirani sitting next to me who was instrumental and I -- has been living and breathing this now for a -- a long time. I'll turn it back over.

DR. BOUFFORD: Thanks, Gus. I'll -- I'll just take the opportunity to -- to thank you as well and Sylvia and all of your colleagues because I think even in the face of emergency management, this -- and that includes our private sector partners, we -- we kept meeting and people got this work done. And it's pretty astonishing that they -- I think it tells the high priority it plays and also the leadership that it had from within the Department. And I also appreciate the commissioner's support. So it's been a very gratifying process.

Next steps, just so you know where we go after this, the material is up on the website. It is draft at this point. There's still some fine-tuning a lot of it because of the -- of the intervening crises and other things. And then

PHHPC - 12-6-2012 - Albany, New York

as -- as Gus said, there will be modifications along the way. This is really an effort to -- to put the evidence base for goals, objectives, interventions, and metrics, in -- in a sense it's a tool kit for local communities. And the only ones we're -- we're saying, I think which is now linked to our regional health planning and the -- the -- the direction that will come from the Department together with the -- the hospitals and the local health departments in their -- in creating their -- there will be a combined guidance, will be to ask them to select work in two of these areas, one of -- and one of which would be related to disparities.

So, again, we had a discussion. I think one of our clinical colleagues was suggesting a double blind control trial across communities trying different things. We had to agree that we weren't really at that stage, but we will -- we will have measures to track and then, similarly, hopefully get the data improved at the sub-county level, which is a real challenge. We're going to count on colleagues at -- in the community

level to help make that data available.

After the website, we are really actively engaged in organizing a communications plan. There will be a variety of written materials in various formats and materials on the web for multiple audiences, English and Spanish at least.

The other piece that's -- we're going to be getting some support. Again, we're very gratified the Robert Wood Johnson Foundation again because New York is going -- is one of the first really large states to go to for voluntary creditation, is providing us with some support from its communications unit via the Rabin Martin firm to help us think through the communications challenges around the rollout and especially providing materials that are culturally competent and useful at the local community level and then can really how best to get them to communities and get broad community engagement. We know the health departments and the hospitals will be focusing because they are more or less obliged to, but we really want to get more people around the table this -- this round than we were able to do in the

PHHPC - 12-6-2012 - Albany, New York

last round.

There has also been a very important commitment to setting up, now that we have this sort of here's where you're going to go idea to develop, again, a resource package as a framework for implementing this program at local communities, and especially in communities that experience the greatest burden of disease and the greatest health disparity.

So that work we will be doing in conjunction with the Minority Health Council and we'll hope to have something specific out, probably our first round for comment next week, and then it will be available to travel with this package and we'll be really looking at -- at how best to reach and more than reach just involve in from the beginning the -- the -- the vulnerable communities at the local level.

Again, the framework will help deal with the disparities issue. Our plan is a release in January and that could be a blueprint. We are seeking funds for a series of activities and also to try to create some resource capacity at

PHHPC - 12-6-2012 - Albany, New York

least at regional level to work with -- to convene local communities and to help people really walk through what's involved in this, and then we hope we'll -- we will certainly know that the core partners here where the combined guidance comes out on the hospital community service plans and the local health department community health plans, we hope will -- will work together using the Public Health Department's health needs assessment as a base, and then combining together and work that links also to the State Health Improvement Plan.

We hope to have a series of regional sessions and we -- we are tracking the M.R.T. waiver process. It promises resources in this area of regional health planning and public health improvement that we would be very -- very, very beneficial. We will also be continuing our -- our dialogues at the state level across agencies and with state level partners in the ad hoc leadership group because we want to create an environment in which collaboration across agencies at local level and in public private partnerships at local level is enabled and not obstructed or

PHHPC - 12-6-2012 - Albany, New York

seen as strange. We want to sort of create some role model patterns, so I think well -- well look forward to that process as our sort of ongoing responsibility.

Before moving forward with a recommendation, hopefully a motion for -- for approval, Commissioner Shah has been very involved in this process all along, as have our state colleagues. And he reached out to me about some specific language that's in the mental health and substance abuse action plan. And there is -- it includes an explicit tax increase on alcohol sales and a list of strategies. Again, we don't have recommendation or regulatory authority. This is one of the evidence-based suggestions as to an intervention that can work.

Our -- because our intent here is really to provide a menu of evidence based options, the Department and OASIS have recommended some alternative language that would open up the full array of interventions in this area in alcohol and substance abuse that are really drawn from the surgeon general's national prevention strategy and

the C.D.C. preventive services task force guidance. And so we would be sort of taking the focus off of tax increases explicitly, which in this environment are quite unlikely to happen, but if someone wants to take a run of it, they -- it will be included in the language. We hope the document would be -- will -- we're proposing new language for that segment of the document that, rather than focusing on specific items, would say the following, consider evidence based strategies to reduce underage drinking such as those promulgated by the U.S. Surgeon General and the Centers for Disease Control and Prevention. So, again, it -- it includes a wider agenda. It doesn't focus only on the one intervention. So we would hope with that change, that you could endorse the plan.

Mr. Chairman, I turn it back to you, and happy to answer any questions.

DR. STRECK: Thank you for that comprehensive overview and obviously a tremendous amount of work that's gone into this. It just seems like these amazing efforts get us to the starting line and it's daunting in some regards.

PHHPC - 12-6-2012 - Albany, New York

But thanks very much for all that effort.

Are there questions for Dr. Boufford or for other members of the committee who have labored so diligently here?

Then, Commissioner, I think you wanted to offer a few comments.

COMMISSIONER SHAH: Yeah. I just wanted to thank Dr. Boufford and all of those who've worked so hard on this SHIP, this State Health Improvement Plan. The word that comes to mind is breathtaking. This is an incredible scope of work. And -- and what you've heard just between the committee that Dr. Rugge leads and -- and Jo Ivey Boufford's committee, I -- I think really defines not only the health care space but also the health space.

And -- and I would encourage folks to -- everyone to go through and take the deep dives and make sure you understand all these reports, because if you do, certainly you've earned an honorary master's in public health and probably several other degrees. And I would suggest as a quiz for at least the SHIP part, you -- you define

PHHPC - 12-6-2012 - Albany, New York

the social determinants of health, you define population health, and then finally define the difference and opportunities between health and health care.

So thank you, John, earlier, Jo, and everyone by extension, and I -- I know we have a lot more business to do, so.

DR. STRECK: Another mandatory assignment. Is that what that was? No.

COMMISSIONER SHAH: Unfunded.

DR. STRECK: Unfunded. Right. An unfunded mandate. There we are again. Just can't get away from them. I think we are in a position to have a motion made.

Dr. Boufford, would you like to make a motion?

DR. BOUFFORD: Move to approve the State Health Improvement Plan.

DR. STRECK: There's a motion and a second. Is there further discussion? Hearing none, those in favor of the motion as presented, please say aye.

FROM THE FLOOR: Aye.

PHHPC - 12-6-2012 - Albany, New York

DR. STRECK: Opposed? Thank you. The motion passes.

And thank you, Dr. Boufford, Dr. Birkhead, and all involved.

Okay. We will now move, somewhat behind schedule, but not putting any pressure on Dr. Gutierrez here, to the codes and regulations committee. Thank you.

DR. GUTIERREZ: Thank you very much, Mr. Chairman. The Codes, Regulation, and Legislation Committee reviewed three regulations earlier today, one regarding nursing home sprinkler systems is for adoption, one regulation for permanent and emergency adoption prohibiting synthetic phenethylamines and synthetic cannabinoids, and also a proposal regarding ionizing radiation which is only for information.

Nursing home sprinkler system, you have already heard in previous meetings. This is for adoption, and a federal mandate specifies that on or before August 13, 2013 all nursing homes must be protected by a supervised automatic sprinkler system. This measure is proposed to help

PHHPC - 12-6-2012 - Albany, New York

financially distressed nursing homes become compliant with the federal provisions and to incentivize lenders to lend to these nursing homes by requiring that the payments made be deposited on a dedicated account that is to be used solely to pay this debt service. The committee unanimously voted to recommend adoption to the full Council and I so move.

DR. STRECK: There's a motion and a second. Is there discussion? Hearing none, those in favor of the motion as presented, please say aye.

FROM THE FLOOR: Aye.

DR. STRECK: Opposed? Thank you. The motion passes.

DR. GUTIERREZ: The next item on the agenda was a proposal on for adoption that would prohibit synthetic phenethylamines and synthetic cannabinoids. The purpose of this measure is to prohibit the manufacture, sale, distribution, and possession of synthetic phenethylamines, more commonly known as bath salts and synthetic marijuana. The regulation defines

PHHPC - 12-6-2012 - Albany, New York

thirteen specific phenethylamines, along with a catchall that would include any compound that has a similar chemical structure allowing the Department and law enforcement to keep up with illegal activities of those individuals seeking to change this structure, to avoid the existing drug laws. Twelve separate classes of synthetic marijuana are defined, as well. The committee unanimously voted to recommend adoption to the full Council and I so move.

FROM THE FLOOR: Second.

DR. STRECK: There is a motion and a second. Is there discussion? Hearing none, those in favor of the motion as presented, please say aye?

FROM THE FLOOR: Aye.

DR. STRECK: Opposed? Thank you. The motion carries.

DR. GUTIERREZ: Short time to go for lunch. The committee unanimously voted to recommend adoption to the full Council on -- forget about that.

The emergency version of the

PHHPC - 12-6-2012 - Albany, New York

provisions to prohibit synthetic phenethylamines and synthetic cannabinoids was also reviewed by the committee. This version is identical to the permanent version. It is on in addition to the permanent version to make sure it does not expire before the permanent version takes effect. The committee unanimously voted to recommend adoption to the full Council and I so move.

FROM THE FLOOR: Second.

DR. STRECK: There is a motion and a second. Is there discussion? Hearing none, those in favor of the motion as presented, please say aye.

FROM THE FLOOR: Aye.

DR. STRECK: Those opposed? Thank you. The motion carries.

DR. GUTIERREZ: The last item on the agenda in -- only for information concerns ionizing radiation. Part 16 of Title 10 N.Y.C.R.R. of the Sanitary Code is being amended to update and add new requirements for the use of radioactive material and to update and consolidate requirements currently contained in Industrial Code Rule 38.

PHHPC - 12-6-2012 - Albany, New York

Most of the proposed changes are promulgated to ensure compatibility with those of the U.S. Nuclear Regulatory Commission and are required as part of New York State agreement with the N.R.C.

Other changes include x-ray equipment, registration updates, and clarification of current requirements for certified radiation equipment safety officers.

That, Mr. Chairman, complete -- completes my report. Thank you.

DR. STRECK: Thank you, Dr. Gutierrez.

Are there additional questions for Dr. Gutierrez or members of the Codes and Regulations Committee? Hearing none, that will conclude that report. That will bring us to the point in our discussions where we will break for lunch.

We will resume at one o'clock straight up. We will start at that time. Those of you who are sending out for food, you may remain here. The rest may go look for food. So thank you. We're adjourned for the moment.

PHHPC - 12-6-2012 - Albany, New York

(A luncheon recess was taken at 12:38 p.m.)

DR. STRECK: Okay. We're ready to reconvene the meeting of the Public Health Council. We are now in possession of a quorum and we will begin with the next component of the meeting and that is the Project Review and Establishment Committee recommendations.

Mr. Kraut?

MR. KRAUT: Just, you know, before I begin, just one or two little things. I just want to share and add -- I'm not going to repeat what everybody said about Rick Cook. In my tenure as chairman of the predecessor council for the State Hospital Review and Planning Council, I got an opportunity to work with Rick quite closely and I can just attest to the content of his character. You could not have a better human being doing that job, who every day came to work trying to fundamentally do what is right and what is better. And I just want to add those comments as well, Rick.

The other thing, Mr. Chairman, we

PHHPC - 12-6-2012 - Albany, New York

often celebrate achievements of our council members. Unfortunately, Mr. Fensterman is not here, but I didn't want the occasion to pass without making you aware of a special honor that was bestowed upon him. As we know, Mr. Fensterman is quite a character and if any of you are avid readers, a book came out by Nelson Demille. It's called "The Panther". It's on the New York Times best seller list and that -- there is a character in that book called Howard Fensterman and yes, it is, in fact, our Howard Fensterman who, through an act of charity, was written into the book as a character. He is introduced as the chief legal attache for the United States in the Yemen ambassador and embassy. And they did reference, in his background when they were developing the character, that he was chosen for this assignment in probably one of the most dangerous and difficult countries in the world, to do U.S. policy because of his work in New York State on the Public Health Council. However, the editor, I was told, felt that that was an obscure reference to readers and therefore it was edited out. Little do they know

PHHPC - 12-6-2012 - Albany, New York

how well they captured Howard, but in all seriousness, he is a character in the book, if you -- it's a quick read. It's called "The Panther." It's on the Times best seller and his hysterical when I got to it and I said Howard Fensterman, that was our Howard Fensterman.

I'd now like to provide the report of the November the 15th meeting of the Establishment Project Review Committee. And I have a special thanks for Mr. Booth who chaired that committee and I have the opportunity to present the results of his efforts as long as -- as well as that of the members.

I am now going to batch category two. These are applications recommended for approval with the following. We had no member recusals where there was no dissent by the H.S.A. or within the committee. Application one two two zero five five C, Erie County Medical Center, recommended approval with contingencies.

Application one two two zero three two C, Corning Hospital, approval recommended with conditions and contingencies.

PHHPC - 12-6-2012 - Albany, New York

Application one two one four six six C, Long Island State Veterans Home, application approval recommended with conditions and contingencies.

Application one two two zero five C, Lutheran Augustana Center for Extended Care and Rehabilitation, approval recommended with conditions and contingency.

Application one two one two three zero C, New York Dialysis Center, doing business as F.M.S. Southern Manhattan Dialysis Center -- oh, Manhattan Dialysis Center, disapproval recommended as proposed, approval recommended as amended by the Department with conditions and contingencies.

Application one two on two four eight C, Elderserve Long Term Health Care, an interest declared by Mr. Fassler and Ms. Regan, approval recommended with a contingency. And I so move.

FROM THE FLOOR: Second.

DR. STRECK: A motion and a second. Discussion on the motion? Hearing none, those in favor, aye?

PHHPC - 12-6-2012 - Albany, New York

FROM THE FLOOR: Aye.

DR. STRECK: Opposed? Thank you. The motion carries.

MR. KRAUT: I have now application one two one two five five C, Visiting Nurse Association of Western New York. I have a conflict recusal declared by Mr. Booth and Mr. Robinson.

MR. BOOTH: I'm going to withdraw my recusal.

MR. KRAUT: So, you're going to make it an interest?

MR. BOOT: I'm going to declare an interest.

MR. KRAUT: Okay. So, a recusal and conflict has been declared by Mr. Booth. I have an interest declared by Ms. Hines and Mr. Robinson. This application is to expand the service area of the CHHA into Steuben County and to convert their special needs CHHA into a general service CHHA. Upon approval, they will all have a CHHA -- they will have a CHHA with approval to provide services to the residents of Alleghany,

PHHPC - 12-6-2012 - Albany, New York

Cattaraugus, Chautauqua, Erie, Genesee, Niagara, Orleans, Steuben, and Wyoming Counties. O.H.S.M. recommended approval. The Establishment Review Committee made no recommendation because of a lack of quorum. And I so move the application.

FROM THE FLOOR: Second.

DR. STRECK: There's a motion and a second. Is there a discussion on this application? Mr. Robinson?

MR. ROBINSON: I think that the application itself and the process by which the certified home health agency proposals have been coming forward have identified, I think, a bit of a gap in the R.F.A. process. And I'd like to express some concern that perhaps as we have been looking at C.O.N. review, we may need to look at that particular provision and ensure that at least when it comes to establishment of new entities for licenses for new geographic areas, that those actually not be exemptions to the C.O.N. process.

And the reason I raise that is because it seemed somewhat unclear as to what the overall purposes of these M.R.T. related

PHHPC - 12-6-2012 - Albany, New York

applications were, especially when it comes to geographic areas and the criteria for how much of a competitive environment needs to be established in order to make those viable. And I'm not suggesting that there isn't a need for that, but just that that piece of that application just came through in such a way that it did not make that apparent or understandable as part of the process. And so, there's a fair amount of confusion regarding that.

So, I actually am going to support this application, but wanted to just express that we consider some modification to the provisions of the proposed C.O.N. reform to capture that gap, which I think exists in the process as it relates to R.F.A.s. So thank you.

DR. STRECK: Are there comments from the staff about this R.F.A. C.O.N. dichotomy that you want to make now or we can defer it, whichever you want to do, Karen?

MS. WESTERVELT: Well, we can defer and I can take questions, if necessary, but we can -- we can actually -- can you hear me? No? Okay. So, you know, we have not competitively

PHHPC - 12-6-2012 - Albany, New York

reviewed these R.F.A. applications. We've been taken them on their individual merit, but you're right, moving forward as part of the C.O.N. redesign, we need to look at how we're going to be reviewing these applications moving forward.

DR. STRECK: Okay. Thank you for that clarification. Thank you for bringing that point up. We're back to the motion, which is specific to the application. Are there further comments on that from any members of the Council? Hearing none, there was a second; correct? You made a motion and we have a second?

So, those in favor of the motion, aye?

FROM THE FLOOR: Aye.

DR. STRECK: Opposed? Thank you. The motion carries.

MR. KRAUT: Now, we have category one applications, recommendations for approval, no issues, recusals, abstentions, or interest declared. I will batch the following applications. Application one two one one zero six B, Enchanted Dialysis, L.L.C., doing business as the

PHHPC - 12-6-2012 - Albany, New York

Newark-Wayne Dialysis Center, disapproval as proposed, recommended approval as amended by the Department with conditions and contingencies.

Application one two one zero one seven B, Surgery of Tomorrow, L.L.C., recommendations for contingent and conditional approval with the expiration of the operating certificate five years from the date of its issuance.

Application one two one three nine B, I.D.H.C., L.L.C., doing business as the Island Digestive Health Center, the recommendations of -- for O.H.S.M. and the committee were conditional and contingent approval with the expiration of an operating certificate five years from the date of its issuance was recommended.

I Application one two one four one two B, L.I.E.A.C., L.L.C., doing business as the Long Island Digestive Endoscopy Center, recommendation for conditional and contingent approval with an expiration of the operating certificate five years from the date of issuance.

Application one two two zero

PHHPC - 12-6-2012 - Albany, New York

seven one B, 21 Reade Place, A.S.C., L.L.C., I have to read additional contingencies into the record so just bear with me. Submission -- contingency one, submission of a signed agreement with an outside independent entity satisfactory to the Department of Health beginning in the second year of operation. These reports should include data showing actual utilization including procedures, data showing breakdown of visits by payer source, data showing number of patients who needed follow-up care in a hospital within seven days of after ambulatory surgery, data showing number of emergency transfers to a hospital, data showing percentage of charity care provided and number of nosocomial infections recorded during the year in question.

Number two, submission by the governing body of the ambulatory surgery center of an organizational mission statement which identifies, at a minimum, the population and communities to be served by the center, including underserved populations, such as racial and ethnic minorities, women, and handicapped persons and the

PHHPC - 12-6-2012 - Albany, New York

center's commitment to meet the health care needs of the community, including the provision of services to those in need regardless of ability to pay. The statement shall also include commitment to the development of policies and procedures to assure that charity care is available to those who could not afford to pay.

Contingency number three, submission of a statement acceptable to the Department that the applicant will consider creating or entering into an integrated system of care that will reduce the fragmentation of the delivery system, provide coordinated care for patients and report to the Department and coordinated care to patients and reduce inappropriate utilization of services. The applicant will agree to submit a report to the Department beginning in the second year of operation and each year thereafter detailing these efforts and the results.

The committee recommended approval with conditions and contingencies as recommended and as I just stated.

PHHPC - 12-6-2012 - Albany, New York

Application one two two zero six nine E, New Alternatives for Children, approval with contingencies as recommended.

Application one two two zero four six E, Hamilton Park Nursing and Rehabilitation Center, recommending approval with contingencies.

I have now the following Certificates of Amendment of the Certification of Incorporation. AIDS Community Service of Western New York to retroactively change its name to E.H.S., Inc., New York Foundation for Eldercare to change its name to the New York Foundation for Elder Care, Horizon Human Services, Inc. to retroactively change its name to Horizon Health Services, Inc., Jewish Home Foundation, Inc. changed its name to the Jewish Senior Life Foundation. I recommend approval.

Re-stated Certificates of Incorporation. Nassau County A.H.C.R. Foundation, Inc. to St. Elizabeth Seton Children's Foundation, Asian and Pacific Islander Coalition on H.I.V./A.I.D.S to change its name back to A.P.I.C.H.A. Community Health Center which and the

PHHPC - 12-6-2012 - Albany, New York

committee recommend approval.

Certificates of Dissolution, The Child Birth Connection Foundation, Inc., Pinnacle Healthcare, Inc., recommended approval.

Home Health care Licensures, two zero one nine L, Angela Dawn Donahue, doing business as Quality Home Health -- Quality Home Health Care, the recommendation is approval with contingency. And I so move.

FROM THE FLOOR: Second.

DR. STRECK: There's a motion on the floor for these multiple approvals. Is there a discussion? Dr. Berliner?

DR. BERLINER: A question. Charlie, if we're saying as a contingency that the operating certificate expires five years after its date of issuance, when does -- when does an applicant have to resubmit or go -- or go through the process?

MR. ABEL: The applicant really -- should really submit their application approximately six months to a year before the expiration. We do monitor for these limited life

PHHPC - 12-6-2012 - Albany, New York

projects and we do remind applicants of that obligation.

DR. STRECK: Charlie, this seems a major shift in policy, though. I mean, I know we've had some limited life, but these are sort of routine applications for, you know, services and now they really do have a fiscal cliff, if I could use that term, that has -- that has been imposed upon them. I mean, this seems like a fairly major change in policy. Am I incorrect on that?

MR. ABEL: This Council has not seen all of the limited life applications. We actually imposed some limited life applications on administrative C.O.N.s which don't come before the Council to track certain specific situations, unique programs. We want to be able to get reports back about the efficacy of the program or the experience, very similar to some of the recommendations that were -- that are presented -- will be presented this afternoon in the C.O.N. reform paper on that topic.

DR. STRECK: I don't mean to perseverate here, but for special circumstances,

PHHPC - 12-6-2012 - Albany, New York

limited life, I think, has been an accepted process for some time. These seem like pretty boiler plate, you know, endoscopy centers and stuff like that. It just seems to me a shift in policy and I'm just trying to clarify if it's -- if it is.

MR. ABEL: Well, ambulatory surgery centers have always -- our policy has always been to put limited lives on those projects. We -- you know, as you know, we recently moved from a limited life establishment to a limited life on the operating certificate. We haven't re-evaluated whether we should continue that policy for all ambulatory surgery centers or maybe for a selected few. We certainly can do that in the context of the C.O.N. reform activities that are ahead of us.

DR. STRECK: Other comments? Dr. Martin?

DR. MARTIN: It's a -- it's a question I should have asked during committee and I apologize. What does it mean to retroactively change your name?

DR. STRECK: That was my other question. I'm glad you asked that because -- Mr.

PHHPC - 12-6-2012 - Albany, New York

Kraut, that's for you.

MR. KRAUT: No -- no; it's like -- well, you know, let's say you've been calling yourself Sheila for years. All right? And now you go to court and make it legal.

FROM THE FLOOR: I wonder what the answer would come out to be?

MR. KRAUT: Okay. It's all right. Listen, what happens, you know. So, I've had one experience with a corporation where we filed. It's just we kind of did a D.B.A. and somebody woke up and said you didn't really file with the state and get approval and it had to get approval and you had to do it retroactively. So, they're just trying to kind of legitimize, I think, an error on oversight.

DR. STRECK: Okay. Are there any other stimulating comments or questions in regard to this massive package of recommendations Mr. Kraut has presented and has been seconded? Hearing none, those in favor of the recommendations, as presented, please say aye?

FROM THE FLOOR: Aye.

PHHPC - 12-6-2012 - Albany, New York

DR. STRECK: Opposed? Thank you. Okay.

MR. KRAUT: Thank you.

Application one two two zero seven five E, Clifton-Fine Heath Care Corporation doing business as Clifton-Fine Hospital, recommendation approval with contingency.

Application one one two three three nine E, Putnam Operating Acquisition One, L.L.C., doing business as Putnam Nursing and Rehabilitation Center, a conflict had been declared by Mr. Fensterman, who is not here. O.H.S.M., we recommended approval with contingency.

Application one two one one nine E, Eastchester Rehabilitation and Health Care Center, recommended approval. A conflict had been declared by Mr. Fensterman, who is not here.

Application one two two zero nine five E, Queens Boulevard Extended Care Facility Management, L.L.C., doing business as Queens Boulevard Extended Care Facility, again, a conflict had been declared by Mr. Fensterman, who is not in the room. We recommended approval with conditions

PHHPC - 12-6-2012 - Albany, New York

and contingencies. And I so move.

FROM THE FLOOR: Second.

DR. STRECK: A motion and second on these recommendations? Any discussion? Hearing none, those in favor, Aye?

FROM THE FLOOR: Aye.

DR. STRECK: Opposed? Thank you. The motion carries.

MR. KRAUT: Now calling application one two one three four seven E, Hollis Operating Company, Inc., doing business as Holliswood Center for Rehabilitation and Healthcare, a conflict recusal has been declared by Mr. Fassler, who has left the room, as well as Mr. Fensterman, who is not in attendance. The committee recommended approval with contingencies. And I so move.

FROM THE FLOOR: Second.

DR. STRECK: Moved and seconded. Is there a discussion on the recommendation? Hearing none, those in favor, aye?

FROM THE FLOOR: Aye.

DR. STRECK: Opposed? Thank you.

PHHPC - 12-6-2012 - Albany, New York

The motion carries.

MR. KRAUT: Could you ask Mr. Fassler to please return? Let me make sure I do this right. So, I did that one.

Okay. Application one two one one two zero E, Premier Home Health Care Services, Inc., an interest declared by Ms. Regan, recommendation for approval with contingency.

Application one two one two four zero E, Your Choice at Home, Inc., interest declared by Mr. Fassler, recommendation for approval with conditions and contingencies.

Application one two one two six three E, Selfhelp Family Home Care, Inc., interest declared by Ms. Regan, recommended -- the committee recommended approval with condition and contingencies.

Application one two two one four five E, Gamzel N.Y., Inc., doing business as Revival Home Health Care, a conflict declared by Mr. Fensterman, who is not in attendance today. We recommended approval with conditions and contingencies.

PHHPC - 12-6-2012 - Albany, New York

Then I have amended and restated Certificate of Incorporations. Oh, wait -- no. I'm going to stop right here. I would like to move that batch.

FROM THE FLOOR: Second.

DR. STRECK: The applications, as noted by Mr. Kraut, have been moved and seconded for approval. Is there any further discussion on any of these? Hearing none -- oh, I'm sorry. Ms. Regan?

MS. REGAN: Oh, thank you. I apologize for not being at the committee, but is Revival, is that a limited -- a special needs CHHA or --?

MS. FULLER-GRAY: Yes, it is.

MS. REGAN: And it's now being established as a regular CHHA -- full CHHA?

MS. FULLER-GRAY: No; this is for a change of ownership.

MS. REGAN: Change of ownership.

MS. FULLER-GRAY: Change of ownership.

MS. REGAN: And was there a look

PHHPC - 12-6-2012 - Albany, New York

at whether they were in compliance -- whether they are in compliance with their special needs -- will they continue to be a special needs CHHA?

MS. FULLER-GRAY: They will continue be a special needs CHHA, yes, and we have some compliance numbers and Linda's going to check them. Our most recent numbers reflect January through June of 2012 and they demonstrate a compliance of approximately forty-seven percent of the population they serve meet their special need criteria, which is less than the ninety-five percent that we had to come up with in September.

MS. REGAN: Yes, I remember. It was -- and did anybody look at their website to see if their website held them out as a special needs CHHA or held them out as a full service CHHA?

MS. FULLER-GRAY: I haven't looked at their website in recent months, but I've reviewed it previously and their website does indicate that they provide services to a special population, Holocaust and Russian Orthodox survivors, in addition to providing other certified home health agency services.

PHHPC - 12-6-2012 - Albany, New York

MS. REGAN: Okay. Well, you know, I don't want to be the nasty one who holds up the show here, but the Department, I guess by approving -- recommending approval is saying that, in your view, they're in compliance with the scope of their license?

MS. FULLER-GRAY: The Department is recommending approval for the change of ownership, not for a change in the status as a special needs CHHA. We would still expect them to try to reach compliance in serving the special needs population that they are approved to provide services for.

MS. REGAN: Okay. Thank you.

DR. STRECK: Well, just following up on that question, when would be the next time the Department would do that other than this rather opportune time, I guess would be a reasonable question?

MR. COOK: Let me weigh in for the last and final time. I think in this -- in this circumstance, if I can say this as direct as possible, we believe the change in ownership gives

PHHPC - 12-6-2012 - Albany, New York

us a much better chance to ensure compliance. And that was part of the discussion with the Department in the change of ownership. So, I think we can establish a schedule that would probably, on an annual basis, be tracking this but we have made very clear to the new owners that we expect them to continue to move to full compliance. I don't know if that helps, but if it doesn't, then I'm not going to be here, so --.

DR. STRECK: Sue?

MS. REGAN: Yeah, it helps. I'm looking here at a budget of a hundred seventy-six million dollars revenues, Medicaid money. Just -- just commenting, I don't -- you know, I don't want to -- I don't know what to make of this but I will respect the Department's recommendation and the committee recommendation.

MR. COOK: If I may --?

DR. STRECK: Like you said, that was your last.

MR. COOK: I know.

DR. STRECK: No. Okay. Go ahead.

PHHPC - 12-6-2012 - Albany, New York

MR. COOK: Thank you. I mean, I think there obviously has been a history and a concern with the role in the future of special needs CHHAs. And we have not dealt with it in a comprehensive manner but had been gone to last year, as part of the Medicaid budget, it began a transformation that will hopefully transition these CHHAs. I think on this particular case, there has been, in the past, significant concerns and I think what we're trying to do is lay the foundation without disrupting the legitimate care that they give to their population to moving to better compliance. And I think we feel comfortable that we are going to have them on a short leash, but this -- you know, this, I think, gives us a better chance to move to that compliance.

DR. STRECK: Other comments from other members of the Council? So, there is a motion and a second. It includes the applicant about which the discussion just took place. Those in favor of the motion as presented, please say aye?

FROM THE FLOOR: Aye.

PHHPC - 12-6-2012 - Albany, New York

DR. STRECK: Opposed? Thank you.

MR. KRAUT: I have amended and re-stated Certificates of Incorporation where a conflict has been declared by Dr. Berliner, who is leaving the room and tidying up a bit.

MR. KRAUT: Health Alliance, Inc., changed name to Health Alliance Hospital, Mary's -- Mary's Avenue Campus and Health Alliance Hospital, Broadway Campus. Benedictine Hospital changed their name to the Health Alliance Hospital, Mary's Avenue Campus and Health Alliance Hospital, Broadway Campus. The Kingston Hospital changed their name to the Health Alliance Hospital, Mary's Avenue Campus and Health Alliance Hospital, Broadway Campus. And the committee recommended approval of these changes.

FROM THE FLOOR: Second.

DR. STRECK: Moved and seconded. Discussion on any of the recommendations? Hearing none, those in favor, aye?

FROM THE FLOOR: Aye.

DR. STRECK: Opposed? Thank you.

MR. KRAUT: Could we ask Dr.

PHHPC - 12-6-2012 - Albany, New York

Berliner to please return into the room?

I am now going to call the next batch of the home health agency licensures. So, I'd just like to read a correction for the record. Two zero two two L Light One O One, Inc., was inadvertently listed as two one two two L. Please note that this -- that -- so, I just want to let -- make you aware of that.

I'm just going to read the numbers and I'm not going to mention the names of the organizations. So, for these licensures it's two zero one two L, one nine four one L, one six six three L, one nine two one L, one nine eight four L, one nine seven eight L, one six nine seven L, one eight zero nine L, two zero zero two L, one nine nine seven L, two zero one four L, two zero zero three L, two zero two six L, one nine three four L, two zero four four L, one nine eight eight L, one nine nine three L, two zero two two L, two zero one one L. And the committee recommended approval with contingency. And I so move.

FROM THE FLOOR: Second.

DR. STRECK: Thank you for that

PHHPC - 12-6-2012 - Albany, New York

numeric mastery.

We have a series of recommendations for which there is a second. Is there any discussion? Hearing none, those in favor, aye?

FROM THE FLOOR: Aye.

DR. STRECK: Opposed? Thank you.

MR. KRAUT: I believe there's a powerball number in the permutation of those numbers. A winner there.

Okay. Category for applications. Application one two two one four seven B, V.R.N.C., L.L.C., doing business as Vestal Park Rehabilitation and Nursing -- Rehabilitation and Nursing Center, an interest declared by Mr. Booth. The committee recommended approval with conditions and contingencies with one member abstaining. And I so move.

FROM THE FLOOR: Second.

DR. STRECK: Moved and seconded. Any discussion? Hearing none, those in favor, aye?

FROM THE FLOOR: Aye.

DR. STRECK: Opposed? Thank you.

PHHPC - 12-6-2012 - Albany, New York

MR. KRAUT: Mr. Chairman, that's the report of our committee. Thank you very much.

DR. STRECK: Thank you, Mr. Kraut.

We'll now move to the consideration of the report of the Health Planning Committee, the second of our major considerations today. This, I think, is a very important report. It represents an amazing amount of work on the part of members of the Council and others within the entire health care spectrum. I think it is important, as was the report earlier by Dr. Boufford, in that this is part of discharging the responsibility of this Council.

The report we're about to hear has more specific operational implications for health care providers in the state. It is aspirational as was the first report, but it is also logistical and technical and that is why there has been so much discussion. What we will be receiving is the work of the committee. It is not the work of the Council until the Council discusses the recommendations and, as a group, approves or

PHHPC - 12-6-2012 - Albany, New York

disapproves the recommendations.

I think it very important that this process in reviewing the planning report be one that can be characterized in retrospect as thoughtful, deliberative, but that does not mean it cannot be done with alacrity. So, I want the group to pay attention as we move through this.

It's also apparent, based on the unsuccessful one o'clock start time that there are members of our Council who are challenged in terms of time and for that reason I want to outline the schedule that I think we will follow here over the next few moments so that we have a sense of the time we have to spend and how we would spend it wisely. We've done a survey. We believe that we have until three o'clock -- three fifteen before we will be losing a quorum from the group. So, that is our timetable to consider these most important considerations.

To expedite the process and to ensure that everyone feels that there was a level of comfort with every recommendation, we will follow the following process which has been cleared

PHHPC - 12-6-2012 - Albany, New York

with our Council here. We will use a batching process and you may want to scratch these numbers down. It might prove helpful. We will consider Recommendations One to Five from the Health Planning Report, as a group under left category of health planning. We will consider Recommendations Six to Thirteen under a category of C.O.N. and licensure. We will consider fourteen to sixteen under promoting quality, seventeen to nineteen under the heading of governance and twenty to twenty-three under the heading of finally finished. So -- that will be our rough approach today.

Now, to do this in a reasonable fashion, we're going to allot about fifteen minutes to each of these topics, to each group. In that period, Dr. Rugge will present the general theme and he will address the rationale for each of the recommendations, all of which members of the Council have had a chance to read previously. We will not have a motion at that point. We will discuss then in order each of the recommendations within that group and if, at any time, a Council member feels that one of these items requires more

PHHPC - 12-6-2012 - Albany, New York

discussion than has been afforded within the time we've allotted, that Council member may make a motion to move this particular recommendation to the parking lot, as it were, and if that motion is supported by a majority of the group, we will defer that motion for further discussion at a later time. The purpose here is not to impale ourselves on a single contentious issue and fail to cover as much ground as we can today. So, those are the ground rules. If you are unhappy, you have an option to express that and to move something out. I think that we're asking people to be thoughtful in their observations.

And with that, John, why don't you lead off with the first group.

DR. RUGGE: By way of preference, Dr. Shah, would you like to exercise the commissioner's prerogatives or defer your discussion until later?

COMMISSIONER SHAH: Later.

DR. RUGGE: Okay. As Dr. Streck indicated, there are twenty-three recommendations for consideration, all of which have been reviewed,

PHHPC - 12-6-2012 - Albany, New York

re-reviewed, and re-re-reviewed in committee. As important as those recommendations are, I think that the context in this report is both masterful and important. And for that, we thank Karen Lipson. It began with a review of the history of health planning and C.O.N. in New York, especially conducted by Art Streeter from Finger Lakes H.S.A., and moved onto Karen and staff, surveying the performance of C.O.N. around the nation and also assessing the status of health care performance in New York. Then moving on with a paper prepared by Gregory Burke of the United Hospital Fund, a description of the current landscape and more importantly, perhaps, the dynamics have changed that we are facing with implications for new opportunities and new risks to the health care system and to the health of New Yorker's.

With that, there came to be, I think, a shared understanding of the need for realigning the regulatory system, starting with C.O.N., to address emerging and new models of care and also change, sometimes reversed payment methodologies with attendant incentives. So, with

PHHPC - 12-6-2012 - Albany, New York

that as background and I think providing the setting for the work and the deliberations that we did regarding specific recommendations, we will proceed in usual fashion.

As Dr. Streck said, I am to quickly enumerate batch by batch and will do so by delegating to Karen Lipson who will quickly, in a breath or two, indicate that beginning, the first five recommendations pertaining to regional health planning.

MS. LIPSON: Thank you, John. So, I'm starting on page nineteen of your report and these first five recommendations, as Dr. Rugge mentioned, relate to regional health planning. Recommendation One presents an endorsement of regional health planning as a mechanism for bringing together stakeholders to advance the triple aim.

Recommendation Two recommends the creation of multi-stakeholder regional health improvement collaboratives to conduct regional planning activities. And those collaboratives would be a -- would be a neutral and trusted

entity, not controlled by any single stakeholder or type of stakeholder. And they would include representation of all stakeholders including consumers, public health officials, health care providers, payers, business leaders, unions, community based organizations, and others.

Recommendation Three recommends the creation of eleven geographic planning regions, which are on the map behind me. As Dr. Rugge mentioned earlier, Glenns Falls Hospital has asked to participate in both the Capital region and the Adirondack region. And the committee indicated its support for Glens Falls' interest in participating in two regions. Consistent with the regional health improvement collaboratives charge to conduct planning around not just health care, but population health and consistent with the increasing emphasis on ambulatory care, these regions are not principally designed around inpatient referral patterns. They are designed to take into account population health planning activities, ambulatory care planning activities, and existing health planning infrastructure as well

PHHPC - 12-6-2012 - Albany, New York

as migration patterns for inpatient care.

There's an important piece of this Recommendation Number Three, which is that sub-regional and inter-regional planning activities are expected, as well as consideration of intrastate issues.

The regional health improvement collaboratives are charged with advancing each dimension of the triple aim in its region. There are a number of examples of the types of activities under each dimension.

Recommendation Five includes a -- includes the fact that the PHHPC should consult with the regional health improvement collaboratives concerning regional health -- the regional health and health care environments, unmet needs, and effective planning strategies and information.

I skipped over one other -- one other topic that we discussed in-depth in the committee, which is the role of the regional health improvement collaboratives, if any, in C.O.N. And I think given the length of that discussion, it bears note. This set of recommendations provides

PHHPC - 12-6-2012 - Albany, New York

that C.O.N. review should not be a core or expected function of the regional health improvement collaboratives. Instead, they're expected to undertake proactive health planning, to stimulate new initiatives to meet identified needs, and not to serve as part of the state's regulatory process in approving or disapproving specific proposals.

At the same time, they may have a helpful perspective on any number of matters before this Council, including forthcoming C.O.N. application and they should be free to submit commentary on matters before the council.

DR. RUGGE: Discussion is very, very welcome.

DR. STRECK: Are there comments from Council members about any of these five recommendations?

Hearing none, John, I would now entertain a motion from you as the chair to approve these five recommendations.

DR. RUGGE: On behalf of the committee, I would make that motion.

FROM THE FLOOR: Second.

PHHPC - 12-6-2012 - Albany, New York

DR. STRECK: A motion and a second for the first five recommendations in the planning committee report. Any further discussion? Hearing none, those in favor, aye?

FROM THE FLOOR: Aye.

DR. STRECK: Opposed? Thank you. Those are approved.

So, we'll now move to what's just broadly and loosely categorized as the C.O.N. licensure grouping of items six to thirteen.

DR. RUGGE: There's seven recommendations. Karen?

MS. LIPSON: I'm starting with recommendation six on page twenty-eight. And just an initial background piece of information, as Dr. Streck noted, throughout this report you'll hear about C.O.N. and licensure as two distinct disciplines. I think we tend to think of them together, but I think we need to start looking at C.O.N. and licensure as distinct aspects of our review because to the extent that we're rolling back C.O.N. for a particular type of project, that doesn't necessarily mean we're saying that that

PHHPC - 12-6-2012 - Albany, New York

service or that facility can proceed on an unlicensed basis. States that don't have C.O.N. programs still license health care facilities and services.

So, Recommendation Number Six recommends the elimination of C.O.N. for primary care facilities, whether they are D and T.C.s or hospital extension clinics, but it retains licensure of those facilities. This proposal -- this recommendation, would require that facilities seeking this exemption employ a physician practicing in the specialties of internal medicine, family medicine, pediatrics, obstetrics, or gynecology, and that they would have to provide one or more of those services onsite.

Facilities that provide or intend to provide advanced imaging, radiation therapy, dialysis, or surgery services would not be eligible for this exemption from C.O.N. because those services are capital intensive and in some cases, supply sensitive, and they would continue to require a need review.

The licensing process for those

PHHPC - 12-6-2012 - Albany, New York

facilities would consist of character and competence, if it's a new operator, or compliance and quality, if it's an existing operator. And they would also be reviewed based on the physical plant. They would have to comply with facility construction standards.

One or two stakeholders raised an issue about the acquisition of physician practices by hospitals and D and T.C.s and that sometimes even just a licensing process could delay such an acquisition and threaten access in a community because it is sometimes challenging to bring those physician practices into compliance with construction standards. This proposal would urge the Department to create a process by which those acquisitions could take place and services could be preserved without compromising patient safety or paying inflated rates for facilities that don't meet construction standards. So, we're going to need to work with stakeholders to develop a process that would achieve those goals.

Recommendation Seven relates to health care facility projects that are approved in

PHHPC - 12-6-2012 - Albany, New York

their entirety through an R.F.A. process. To the extent that those projects -- to the extent that regional planning considerations are incorporated into the R.F.A. process, those projects would be exempt from the public need review and from some aspects of the financial review because those elements are typically considered as part of the financial -- I'm sorry -- as part of the R.F.A. process. Just to clarify, any project that would require the establishment of a new health care facility operator would, of course, go -- continue to go through the Public Health and Health Planning Council. That was not intended to be exempted here. The goal here is that if we -- if the Department of Health awards a grant to a provider, the -- there is a need review as part of the R.F.A. process and a second need review is not necessary and there is also some financial review as part of the R.F.A.s and a full- blown financial review may not be necessary either.

Recommendation Eight relates to emerging medical technologies and services that might be appropriate for C.O.N. oversight. It is

PHHPC - 12-6-2012 - Albany, New York

challenging for the Department to stay abreast of capital intensive emerging technologies. And although we want our health care facilities in New York to be at the forefront of those innovations, we also want to make sure that emerging technologies are not adopted prematurely on a widespread basis before we know whether they are effective and have value. So, this proposal urges the Department to contract with an academic or research institution to conduct periodic environmental scans of emerging technologies and highly specialized services to determine whether they might be appropriate for C.O.N. review. And we would take those recommendations to the PHHPC and determine whether a need methodology might be appropriate or whether a health -- whether this service or equipment would be appropriate for our new medical technology demonstration project regulations.

Recommendation Nine relates to hospital beds. We considered whether it is time to eliminate C.O.N. for hospital beds, given changes in payment methodologies that discourage hospital

PHHPC - 12-6-2012 - Albany, New York

admissions and given the fact that many hospitals appear to be voluntarily taking beds out of service. The Council concluded that we should not do that at this time, but that we should re-examine the question in three to five years. I'm sorry; the committee determined that.

Recommendation Number Ten relates to accountable care organizations and whether C.O.N. continues to be necessary or have utility in the context of accountable care organizations that -- that may receive a significant portion of their revenues through risk-based payments. The health planning committee considered eliminating C.O.N. for facilities that receive a substantial portion of their revenues through risk-based payments and participate in these organizations but determined that it would be premature to do that because the A.C.O. certification process has not yet been adopted through regulation, that those regulations are under development. So, that this recommendation asks the Department to reconsider C.O.N. in the context of A.C.O.s once that certificate process is finalized.

PHHPC - 12-6-2012 - Albany, New York

Recommendation Number Eleven is update the C.O.N. process for hospice. Our current need methodology for hospice is heavily based on cancer incidents and it's widely recognized that hospice care is appropriate for a wide variety of terminal conditions. This recommendation asks the Department to update the need methodology to recognize the fact that hospice is appropriate for a variety of conditions.

Recommendation Twelve recommends the updating of the C.O.N. process for approved pipeline projects. Currently, there are providers who receive a certificate of need, but do not act on it. And we do impose deadlines for acting on certificate of need applications but there are sometimes repeated requests for extensions. And this proposal would allow us to continue to impose those sort of short-term deadlines but would impose a hard and fast deadline of two years for establishment projects and five years for construction projects. In the event that a C.O.N. expires, the provider would have to reapply for and receive a C.O.N. approval to go forward.

PHHPC - 12-6-2012 - Albany, New York

And Recommendation Thirteen asks the Department to come back to the Council in six months with options for or recommendations for equalizing the treatment of health care facilities and physician practices under C.O.N. and licensure. It recognizes and the committee discussions recognized that corporate entities are playing a growing role in physician practices and that the line between a physician practice and a diagnostic and treatment center has grown blurry and that there is need for some clarification and perhaps some different regulatory approaches to physician practices and diagnostic and treatment centers than the current approach. And I shouldn't just say diagnostic and treatment centers -- other ambulatory services.

DR. RUGGE: Taken together, I think these recommendations represent a fundamental refocusing or perhaps a sharpening of the focus on C.O.N. with regard to supply sensitive and volume sensitive activities, rather than an across-the-board approach that we've been accustomed to over the decades. It also proposes a

PHHPC - 12-6-2012 - Albany, New York

mechanism for periodic surveying the landscape for emerging technologies that might best be placed under the scope of C.O.N. reviews and also takes a calibrated approach understanding these changes need to be taking place as the system evolves and as we see new models of care and new payment methodologies.

DR. STRECK: Thank you, Karen. Thank you, John.

Comments from members of the Council? Mr. Hurlbut?

MR. HURLBUT: Yes, just under Recommendation Number Seven, one of the things that concerns me a little bit is that I'm hoping that these projects will go to establishment because there's been some projects that have been approved that, in the past, using grant money that -- one that was just decided in Ontario County not to happen, which if it -- if it did and it came to this particular -- through Recommendation Seven, my concern would be that it wouldn't go through establishment which would be an issue with the providers that are in those counties.

PHHPC - 12-6-2012 - Albany, New York

And there's been some grants done in the past and where -- how to say this nicely -- where ninety-nine percent of them have gone to non-profits and the for-profits had -- were also applied and didn't get a chance to find out what happened until it was already done. And I haven't seen some of those projects come forward. I've seen one of them. And my concern is is that if it's not reviewed, it doesn't have to be a full blown C.O.N., but I think if there's been some competing for health care grant funds, that the other facilities have a chance to be able to go, what happened, why weren't we approved?

DR. RUGGE: The thrust is to avoid duplicate reviews within the Department, rather than exempting a project from the purview of the Council or from C.O.N. itself.

DR. STRECK: This is Mr. Robinson's point from earlier, is it not, about the R.F.A. process?

MR. ROBINSON: May I?

DR. STRECK: Yes.

MR. ROBINSON: So, yeah, let me

PHHPC - 12-6-2012 - Albany, New York

build on Mr. Hurlbut's point a little bit here. I think that here we're talking about the issue of how we deal with competitive batches and, in particular, how we structure planning decision that relate to integration of care within a region or within a system versus competition and understanding and structuring the batching process in such a way so that those kinds of issues are clarified prior to the process. So, I'm supporting Mr. Hurlbut's point because I do believe that those kinds of issues really should have the benefit of a review at the Council. So, I understand Mr. Rugge's point about not duplicating the process, but I do want to ensure that we understand the planning parameters clearly enough so that we know what the goals are for a particular region. So, I think regional input is important for this and how that gets put into play and then the ground rules for health planning. So, I have no problem with an R.F.A. process but I think if the R.F.A. process is done only at the state level, it becomes a little bit of an issue when it comes to regional planning.

MR. HURLBUT: And just as a

PHHPC - 12-6-2012 - Albany, New York

follow-up, there were -- I believe it was to HEAL Twenty grants, where there were quite a few for-profits that took exception to what was given out and that it was done afterwards. And a matter of fact, I applied for a grant and I met the criteria by a hundred percent and wasn't even spoken to about it until it was awarded to somebody else. And that can happen. And I don't know if this directly under number seven or if you want to put it under number twenty-eight, which doesn't exist yet, but that kind of thing has got to stop because it's not fair to the rest of the providers and with managed care coming in especially. For Medicaid long term care residents, it's going to even be more of an issue down the road. So, I just want to make sure that everybody gets a fair chance.

DR. RUGGE: Your point is very well taken. I think that the hope is in the first five recommendations that we've created the beginning of a structure for regional planning. There is no question we need to live out that process and test and, region by region and through

PHHPC - 12-6-2012 - Albany, New York

this Council, look at and resolve the kind of issues that you've brought up.

DR. STRECK: For the Council, I mean, we have to decide if this language is acceptable or if it wants to be modified, if we want to talk about it more. I mean, each -- on each of these items, I think those are the criteria we just want to go through, make sure we're comfortable.

MR. ROBINSON: Perhaps there's a modification language here that may help to address this without turning the whole applecart over but where it says regional health planning considerations can be captured through the award criteria, I think if there is a little bit more of a proactive requirement about that in the establishment of the -- of the R.F.A. criteria, we may be able to get at that -- at that issue.

DR. RUGGE: And there is precedent for this inside the 1115 waiver where time and again, there are indications that these new regional planning entities will be extending funding preference to selected projects. So, I

PHHPC - 12-6-2012 - Albany, New York

think in other context, this -- only to say this one report can't do everything we would seek to achieve, but are hoping to create a structure in which we can move forward and make progress on all fronts.

DR. STRECK: Mr. Hurlbut?

MR. HURLBUT: Well, my point is that Recommendation Seven can stand as it is. To me, it's in this report when we go through all these different recommendations. The devil is going to be in the details. So, I don't have an issue fundamentally with Recommendation Number Seven until we get to Recommendation Number Seven when we get into the details on how it should be structured. I think that's, you know -- so, I can -- I can live with it. I don't want to --

DR. RUGGE: Right.

MR. HURLBUT: -- as Ms. Regan put it, blow anything up, but I think we can just -- when we do number seven and it gets into the specifics, we really got to make sure that it's written up properly.

DR. RUGGE: And we hope to have

PHHPC - 12-6-2012 - Albany, New York

you here for those discussions.

MR. HURLBUT: Well, hopefully, if I get reappointed, I might be here.

DR. STRECK: Are there other questions? Dr. Berliner?

DR. BERLINER: If I install a new technology that hasn't been determined yet because the environmental scan hasn't taken place, in my facility in such a way that it doesn't require a review, my assumption is if Council then decides that this is something that has to be -- that is reviewable for a C.O.N., that this is grandfathered in?

DR. RUGGE: I would presume so.

DR. BERLINER: And so, my concern is only that because that process of doing the scan and the Council coming to some kind of an agreement might take a while, there might be a kind of a rush to get stuff in before the regulation starts? I'm not sure how to address that, but it's just a concern.

DR. RUGGE: Yeah. The best and perhaps only precedent over the discussions with

PHHPC - 12-6-2012 - Albany, New York

respect to proton beam in which there was a deliberate move in an anticipatory way and, in effect, I think this recommendation hopes to replicate that experience through a systematic review of new technologies, rather than waiting by chance.

DR. STRECK: This is Recommendation Eight we're talking about; correct?

DR. RUGGE: Yes.

DR. STRECK: Okay.

DR. RUGGE: Yes. Thank you, Howard.

DR. STRECK: Are there other comments or questions? I have one regarding Recommendation Six. I guess what I'm trying to understand here is the -- between licensure and C.O.N., there is a parsing that can occur, but our experience as Council, we've confronted competitive primary care applications. Would -- under this new approach, would both be afforded licensure, absent a C.O.N. review? In other words, would primary care essentially become a non-competitive licensure process?

PHHPC - 12-6-2012 - Albany, New York

DR. RUGGE: The committee and also the stakeholders deliberated extensively on this issue and decided it's really untenable to say we have a crying need for more primary care, no evidence of overuse or the risk of overuse, and therefore, is simply looking at eliminating public need as a standard within the -- within the license -- yes, if there are multiple applicants and if those potential licensees met the criteria for licensure, they would become licensed.

DR. STRECK: Okay. I personally think that's a good idea, but I was just wondering if that was the intent.

DR. RUGGE: Yeah.

DR. STRECK: Thank you.

DR. RUGGE: Yeah. And again, just another example of the number of memos and conversations and calls and the length of community discussion on that, among many other issues, but we do feel that was -- that had rather thoroughly -- including with the primary care organizations who would be affected.

DR. STRECK: Other comments?

PHHPC - 12-6-2012 - Albany, New York

Yes, Dr. Sullivan?

DR. SULLIVAN: Yeah, just -- it's just a comment on number ten, on A.C.O.s. And I think that you have the caveats in here of -- but again, I think the devil will be in the details. And just to emphasize, I think the importance of setting up, whether it's through C.O.N. or certification, some real tracking of what happens, not just when you start it, but what happens over time. If this were to come to full force, it would really make major changes in the health care system. So, I think some preparation of however you want to do it, of what you want to monitor over time to just see the impact on critical things like access. I think you have it in here, but I think it's a very important point that that timeline be included.

DR. RUGGE: As you know, this is phase two of our work. And I understand under phase three there will, indeed, be a look at A.C.O.s and implications for all we do. So once again, this is by no means a definitive report. It is the beginning of refocusing C.O.N., in the

PHHPC - 12-6-2012 - Albany, New York

beginning of a policy conversation in which this Council will be integral. Yes?

COMMISSIONER SHAH: I'll take this opportunity to just add, what is phase three? You know, what -- this body of work is extremely important, you know, we need to get past this because there is an aggressive agenda, not only things like disaster or preparedness and response we discuss, but certainly advising on our regs related to A.C.O.s. We have SEPSYS (phonetic) coming up in January. We have Certificate of Public Advantage. I'd like to see, you know, additional look -- looks into the oversight of large multi-specialty medical practices and then certainly new models of care, you know, upgraded D and T.C.s. So, there is a lot of work left to be done and that's why there's a sense of urgency to continue to seek progress in real time on passive parent, on all of the things that we are considering today.

DR. RUGGE: Thank you.

DR. STRECK: Are there other comments on Recommendations Six through thirteen?

PHHPC - 12-6-2012 - Albany, New York

I would just point out, Recommendation Ten essentially recommends -- we recommend to the Department of Health that they come -- they seek our opinions. So, I think that one seems relatively safe from the Council viewpoint. Are there -- six to thirteen.

DR. RUGGE: We trust it's not a violation of the Stark Law for self-referral.

DR. STRECK: That's right. Six to thirteen. Going, comments? John, we'd entertain a motion?

DR. RUGGE: I would so move.

FROM THE FLOOR: Second.

DR. STRECK: Item six to thirteen have been moved and seconded. Is there a further discussion, comments? Hearing none, those in favor, aye?

FROM THE FLOOR: Aye.

DR. STRECK: Those opposed? Thank you.

DR. RUGGE: I would -- I would like --

DR. STRECK: Fourteen to sixteen?

PHHPC - 12-6-2012 - Albany, New York

DR. RUGGE: -- I would note that we're already past the midway mark and would turn to Karen for the next three.

DR. STRECK: Don't get cocky. Just keep going. Okay?

MS. LIPSON: These three recommendations relate to our process for approving operators of health care facilities and they attempt to do a couple of things. The first one attempts to eliminate barriers to integration of systems and recruitment of experienced leadership. And the second two relate to aligning character and competence reviews with the growing complexity of health care organizations.

So, I'll start with number fourteen, which is rationalize taint. Taint is our colloquial term for disqualification of applicants to operate health care facilities and home care agencies. And right now we disqualified -- we have a mandatory disqualification of applicants who have recurring violations that threaten health and safety. This has created some problems in implementation as facilities and health care

PHHPC - 12-6-2012 - Albany, New York

organizations become more complex and individuals are linked to more health care facilities and organizations, there's a greater likelihood, but they would have two or more violations of health care regulations in their background.

In addition, the -- because of this, this mandatory disqualification discourages experienced people or deters experienced people from going into additional health care organizations because of the fact that they are more likely to have violations in their background. So, this proposal would create a more flexible approach to disqualification. Instead of looking at two or more violations of the same regulation as the grounds for disqualification, it would look at whether or not there is a pattern or multiple pattern of or multiple violations, that evidence of failure in governance or systemic weaknesses.

In addition to looking at violations, this proposal would also look at satisfaction of quality benchmarks. It may be that there isn't a pattern of multiple enforcements or a pattern of or multiple enforcements but that there

PHHPC - 12-6-2012 - Albany, New York

is abysmal performance on quality benchmarks. We've recognized that those benchmarks have yet to be adopted. Our Office of Quality and Patient Safety is developing dashboards for various health -- types of healthcare facilities and we anticipate using those dashboards to measure healthcare providers in their -- in their affiliated organizations.

Even if there is a pattern of enforcements, that would not trigger a mandatory disqualification under this proposal. There would a presumption of disqualification which can be rebutted under limited circumstances. Those circumstances would be the individual's role in the organization and actions to address problems, the timing of his or her involvement in the organization, recent performance, and the extent of his or her involvement in health care organizations. And this proposal would extend not just to the owners or board members of health care organizations but also the C.E.O. or C.F.O. of a facility or agency.

The last piece of this proposal

PHHPC - 12-6-2012 - Albany, New York

is that the focus should not just be on individuals. If an entity is seeking to engage in an establishment action, whether it's a merger or a joint venture, the focus should be on the organization, rather than on the individuals and we should be looking at the organization's compliance and its quality performance and not whether an individual on the board or within the ownership structure has an affiliation with another unrelated facility and that unrelated facility has a poor track record. It really should be a focus on the organization that is applying to undertake an establishment action. So, that's sixteen. I'm sorry; that is fourteen.

Fifteen relates to character and competence reviews of not-for-profit corporations. We are seeing bigger, more complex, not-for-profit corporations. This proposal would impose new requirements on the front end of character and competence and streamline review at the back end. And what I mean by that is established not-for-profit operators would be expected to conduct a character and competence review of their

PHHPC - 12-6-2012 - Albany, New York

own board members when the board member is appointed and the operators would be expected to update that review in the event that they're undertaking an establishment action, like a joint venture or merger.

And instead of the Department of Health verifying the established operator's review, the established operator would attest to that review and disclose any compliance or quality problems. And the Department would still have the prerogative to make recommendations to the PHHPC and the PHHPC would still have the prerogative to agree with or disagree with those recommendations based on the disclosures made by the established operator. So, this would not apply to new operators. This would apply to existing operators that are seeking to undertake an establishment action.

And then Recommendation Sixteen relates to complex proprietary organizations and new complex not-for-profit systems. Under this proposal, complex proprietary organizations -- and what I'm really talking about here are the publicly

PHHPC - 12-6-2012 - Albany, New York

traded or private equity owned home care agencies and dialysis facilities that we permit in New York State. Right now in the homecare arena, we are required to look up and down the corporate chain at each of the entities and their principles and we are required to look at health-related subsidiaries. And the poster child for this was when we had to look at the compliance record of all Walgreen's pharmacies in the country. So, this process sometimes seems like it's not adding a whole lot of value and what we really should be looking at is the principles in the regulated entity and perhaps the parent of that regulated entity and the organization's compliance as a whole.

So, this requires D.O.H. review, as we currently do, of the regulated entity and the parent. And if that parent is a holding company, we would go up the corporate chain until there was an entity that actually had some sort of activity that it engages in. And it would require an attestation by the ultimate parent concerning its controlling shareholders or members and concerning

PHHPC - 12-6-2012 - Albany, New York

the organizational compliance record of the entire organization.

And then a determination could be made by the applicant and D.O.H. about whether a third party review could be substituted for D.O.H. review. That third party review could be conducted by an accrediting organization or by an auditing firm or some other credible organization that the Department approves of and that -- and that would substitute for D.O.H. review if D.O.H. agrees. We would then make our recommendation to PHHPC and PHHPC would have the prerogative to agree or disagree with the recommendation based on the attestation or review and the disclosures. That is it.

DR. STRECK: Okay. Thank you, Karen.

John, do you have any comments, other than that?

DR. RUGGE: No. I think, once again, now taking a looking at governance and review of character and competence is a -- is a next stop, not as a definitive final step.

PHHPC - 12-6-2012 - Albany, New York

DR. STRECK: So, Dr. Berliner?

DR. BERLINER: Karen, a question about number sixteen, in my experience most, certainly not-for-profit boards, don't do what the D.O.H. would consider a character and competence review of new or potential board members. So, this is saying that the D.O.H. would ask all not-for-profits to do such a review?

MS. LIPSON: We would ask established health care facilities to do that review. And it has been pointed out that our Schedule Two-A, the character and competence form that we ask facilities to complete when they're undertaking an establishment action, is long and asks a lot of questions that might not add a lot of value. And we have said that we would work with stakeholders to streamline that form and make sure that the questions are targeted and that they add value to the review.

DR. BERLINER: And if -- and if an established organization decided to add a board member, even if that review was not positive according the standards that get developed, that

PHHPC - 12-6-2012 - Albany, New York

would then become an issue for this -- for this committee to review?

MS. LIPSON: Only if they came before us with an establishment action, just as it would today.

DR. STRECK: Yeah. Right. So, board memberships could still have some fluidity, but it would be an establishment application that would bring this review process forward and there would have been an organizational character and competence review, presumably, on any individuals that could be applied when they came before this group. Is that correct?

MS. LIPSON: Can you repeat the question?

DR. STRECK: Probably not, actually, since it was so ill phrased. Who had a question over here? Mr. Hurlbut? Okay. I'll try again.

MR. HURLBUT: I'm more than happy to give you time to think.

DR. STRECK: Yeah, right.

MR. HURLBUT: On Recommendation

PHHPC - 12-6-2012 - Albany, New York

Fourteen, one of the things I want to make -- I think it's -- again, it's the devil in the details and I don't necessarily want to change it. But for the for-profits, I wish you went from ten years back to three. Having lived through this establishment process before, some of the stuff that we've gone through as an industry really have nothing to do with resident care that we pay some fines on. It has to do with buildings and it doesn't correlate with the F TAGS right now -- you know, the federal F TAGS. You know -- you know, the state is -- interprets it -- some of them differently. And the other issue is sometimes we've -- you know, we've paid the fines and just to get it over with and done because the I.D.R. process, I mean to be thoroughly honest with you, is a joke. It doesn't work.

So, I.D.R., some of our issues that we have during surveys, the citations we get, it's like the wolf is in the hen house. We used to have private meetings face to face and then it went to driving to Albany and then it went to phone calls and then it went to send your letters in, to

PHHPC - 12-6-2012 - Albany, New York

when you try to do the dispute resolution. And we don't win them and then, yet, we pay the fine. We don't agree with that, but we do it and then when we go to establishment it's held against us again. So, it's almost like double jeopardy. So, again, I think in number fourteen, when it's time, I'm not saying -- I think it's -- actually, you're moving in the right direction, is that this needs to be seriously addressed.

DR. RUGGE: Point well taken.

DR. STRECK: Mr. Kraut?

MR. KRAUT: Just going back to Howard's point, I think part of what we were trying to accomplish on Recommendation Sixteen, right, is we're setting a standard and basically saying that if you are going to be part of the governance of an Article 28 facility in this state, we're telling the governing authority that you have a requirement. This is the minimum standard we're asking you to do. We're asking you, it's not enough that you do business with these people, it's your brother's sister-in-law's cousin's nephew. It is the fact we need you to dig a little deeper into

PHHPC - 12-6-2012 - Albany, New York

their background. You have to do things. You have to attest there isn't anything in that background, that when you come forward for an action that requires approval, that person would pass muster. I mean -- I mean, in essence, that's what where -- and for the first time, we're still getting, you know, the stuff that Sue spoke about before and Mr. Hurlbut. You know, we're trying to understand -- we've always -- this pursuit of what is character and competence and I just -- I just want to -- I think this is a good start to tell -- to deal with some of the -- you know, relieve some of the administrative burden, but to tell facilities there is a minimum requirement here, but that's it.

DR. STRECK: Dr. Boutin-Foster?

DR. BOUTIN-FOSTER: Does this include description of the process that they went through to ascertain some of this information? So, what is the process that they went through to do a character and competency review, because since we're not doing it, since the D.O.H. is not doing it, then what's the -- you know, the trail to make sure it was done appropriately?

PHHPC - 12-6-2012 - Albany, New York

MS. LIPSON: I would expect -- and these details have to be worked out, but I would expect that we would ask them to get their board appointees to complete the same form we ask new -- newly established applicants to complete. Can I just add something? In the committee meeting, Sue Regan asked that we add a sentence and I should have mentioned that because I think it goes in Recommendation Fourteen. She asked us to add a sentence, and it would probably go on page thirty-five, that further refinement is needed concerning the concept of character. Is that correct?

MS. REGAN: Well, I would like to go maybe a little further and just say that while we're pulling back a little bit on the tainting, we want to recommend that attention be paid to defining character. Well, let me just say we were talking earlier about -- offline, about how do you do this. And I realized that you can be a trustee of a hospital and be -- I mean there's no standard of behavior as there is for everyone from surveyors, to nurses, to architects, to engineers,

PHHPC - 12-6-2012 - Albany, New York

where there's a standard of misconduct. There's a list in Section 8 of the Education Law, you do these things, you lose your license, but you can be a trustee of a hospital and have done any number of things. And I guess what I'm hoping is that in this whole process, we can come up with some minimal standards for that position. And I would like to somehow express that we want to look at that.

DR. STRECK: Other? May I try again? Under fifteen, where we -- you do the character and competence for a new board member and then the next bullet says require the operator update the review in the event of any establishment action. I mean, is that -- is that the review of that new board member? Is that the review of the entire board? I'm not quite sure what that means?

MS. LIPSON: So, right now, if a health care facility seeks to enter into a joint venture with another facility or a physician practice in order to establish another Article 28 facility, they would have to submit to us those Schedule Two-A's of all of their board members.

PHHPC - 12-6-2012 - Albany, New York

And we would then verify everything in those Two-A's. So, what this says is when you appoint a new board member, you have them complete the Schedule Two-A so you know that they're going to pass muster. And then if you decide you want to enter into a joint venture with another entity, you would have to update those Schedule Two-A's and it's -- even today, you would have to update them because in order to enter into the joint venture, you would have to submit them to us, but we're just asking you to update them. We're not going to verify them. So, that's the difference. You would update them and you would attest to us that you have updated them and that either they pass muster based on our standards or you've identified the following issues.

DR. STRECK: This may just be grammatical, but it seems that the second clause is referring to the first and it's really referring to the entire board.

MS. LIPSON: Okay.

MS. REGAN: So --

DR. STRECK: At least to my

PHHPC - 12-6-2012 - Albany, New York

reading.

MS. REGAN: -- does that mean, Karen, that you could do, like what happened at Peninsula, where they changed the whole board and since it was not an establishment event, they didn't have to attest to the character and competence of their new board members?

MS. LIPSON: I think we're going to get to that in a little while.

DR. RUGGE: We addressed that in another recommendation.

MS. LIPSON: Sorry.

DR. RUGGE: Yes.

DR. STRECK: Okay. Some clarity there. Mr. Kraut has moved the recommendation, usurping Dr. Rugge's privilege --

MR. KRAUT: Oh, I'm sorry.

DR. STRECK: -- for all his good work but --

DR. RUGGE: No.

DR. STRECK: -- nonetheless, you will --

DR. RUGGE: No, go right -- go

PHHPC - 12-6-2012 - Albany, New York

right ahead.

DR. STRECK: We've allowed Dr. Rugge to second the motion.

DR. RUGGE: I will go second.

DR. STRECK: Okay. Well, thank you. So, we now have motions on Recommendations Fourteen to Sixteen. Is there any further discussion, comments? Hearing none, those in favor of Recommendations Fourteen to Sixteen, please say aye?

FROM THE FLOOR: Aye.

DR. STRECK: Those opposed? Thank you. Those recommendations are passed. We'll now move to Recommendations Seventeen through Nineteen.

DR. RUGGE: As I think everyone in the room heard this morning, the committee, only today, was able to meet to do final review and adoption by committee of recommendations regarding the passive parent paragraph. I believe everyone at the table has received revised language that was considered this morning and adopted for recommendation by the committee. And Karen then

can do a very brief review of that because we've already discussed it at great length and in detail with everyone present and then we'll move onto the next recommendation or two.

MS. LIPSON: So, this is Recommendation Number Seventeen, align passive parent oversight with powers exerted by parents. And the amendment that everyone should have in front of them creates a sort of light review process for passive parent relationships. And it provides for a notice to the Department identifying entities involved, board members, affiliation agreement, and organizational documents when a passive parent relation -- or prior to the commencement of a passive parent relationship. The notice would be asked to -- would have to include how the proposed arrangement will benefit the health care facility seeking to affiliate the passive parent and the broader health care system.

The Department would have ninety days to recommend a disapproval to PHHPC. If no action were taken by the Department, the transaction could go forward. Grounds for

PHHPC - 12-6-2012 - Albany, New York

recommending disapproval would be a poor record of compliance, integrity, financial management, or quality on the part of the passive parent or its affiliates, or lack of evidence that the passive parent arrangement would benefit the proposed affiliate as well as the parent and/or existing affiliates.

Approved passive parent relationships would be reviewed every three years. Reviews would be based on the systems compliance record, financial management, quality of care, and evidence that the passive parent arrangement is mutually beneficial for the parent and/or its affiliates. Failure to meet those standards could result in a revocation of passive parent approval or other action.

Affiliates with existing passive parents would not be required to seek the Department's approval of current relationships. So, passive parents that, today, are involved in these types of relationships would not have to come to the Department and submit a notice with a ninety-day review. However, if existing passive

PHHPC - 12-6-2012 - Albany, New York

parents seek to affiliate with new providers, there would be a ninety-day review and they would be subject to the three-year review. And the rest of the Recommendation Seventeen is deleted.

Recommendation Eighteen is approve transparency of major changes in board membership. There is a requirement in our regulations that not-for-profit health care providers report to the Department on their board annually, but that process for doing so is unclear. There's no form to fill out and there's no electronic process for submitting. This recommendation is that we create a more structured process for that and also that there be notification of any change of twenty-five percent or more of the members of a facility board within a twelve-month period.

Recommendation Number Nineteen is strengthen the Department's authority to respond to failures in governance.

Am I going beyond the batch?

DR. RUGGE: No.

MS. LIPSON: Okay. Sorry.

PHHPC - 12-6-2012 - Albany, New York

And this proposal would express the Council's support of legislation to permit the Department to appoint temporary operators of hospitals and diagnostic and treatment centers and to replace board members under extraordinary circumstances where the health and safety of patients is of concern and financial instability threatens patient care.

In addition, this recommendation recommends the expanded use of limited duration operating certificates where new operators are established, where new models of care are created, and where compliance or quality of care issues are identified. And the rationale there is as we move towards greater use of attestation and as we have this growing complexity of health care organizations, we may want to have a more -- a stronger way of controlling facilities that are not performing properly. So, this would create -- this would recommend expanding our use of those limited duration operating certificates. There would be expiration dates on operating certificates with greater frequency where new operators are

PHHPC - 12-6-2012 - Albany, New York

established or where there are new models of care or issues related to compliance or quality that are identified, but that don't preclude approval of a project or an operator.

DR. STRECK: So, by way of summary, three recommendations, looking at improved or updated monitoring of increasingly complex health care organizations and recourse for the State, for the Department to intervene in the event of impending organizational failure.

DR. STRECK: Comments or questions from members of the council?

COMMISSIONER SHAH: So, you know, much has been discussed on the use of passive parents. And I think that we believe that it is of such significance that the Department needs to have some level of oversight of this passive parent model. I think what we've been able to achieve through the conversations in committee and elsewhere is to -- is to strike the right balance. You know, anytime you want to expand regulation, you have to think of unintended consequences. And we've had a great chance to discuss the potential

PHHPC - 12-6-2012 - Albany, New York

for that. So, what we've come up with today is really a testament to this committee that we've been able to make sure that we get what we need out of the rules but we don't overstep our bounds, so thank you.

DR. RUGGE: And the committee thanks the Commissioner for the personal involvement you've had and the monitoring you've done of us.

DR. STRECK: I don't mean to be contrary. I just want to ask a question about the passive parent. It seems to me that if a not-for-profit board spends a year or so going through a process of deciding that they are willing to align and they expend hundreds of thousands of dollars in resources to effect such a change because they believe it is in the best interest of their organization, their fiduciary responsibility, and they have the corporate laws of the state that allow them to do this, I'm just curious as to our thoughts about how a regulation can disapprove such an action, in legal terms?

MS. LIPSON: In the homecare

PHHPC - 12-6-2012 - Albany, New York

arena, we have, through regulation, reviewed passive parent arrangements. And I'm not sure about the sequencing of that, you know, whether the not-for-profit corporation law comes first or whether the D.O.H. review comes first, but we do review those arrangements.

DR. STRECK: I think it's a question that will be answered one way or another, but I just -- I think that is an issue we have to confront about this particular approach, that we are essentially agreeing to a regulation that would supersede, what I perceive at least, I think is corporate law that is established here. So, it leaves us with some further questions perhaps and -- or more detailed answers at another date but that is -- that has been my concern about this. I'm fully cognizant of the concerns of the Commissioner and the committee, but I have expressed to the Commissioner and to this group that I think this is a question that it remains unanswered in my mind.

DR. RUGGE: Mr. Dering, have you had a chance to look at this?

PHHPC - 12-6-2012 - Albany, New York

MR. DERING: I haven't looked at it but in terms of if the Department's going to regulate control of an entity, then I think it would have the authority to have requirements that are in addition to whatever exists in corporate law. So, I haven't looked at the issue, but that would be my response at this time.

DR. RUGGE: It sounds like that would be a next step.

MS. REGAN: One short answer is though it just -- it would take a statutory change. Isn't that the -- wouldn't it likely -- in home care, it's by statute.

MS. LIPSON: Actually, it's in regulation.

MS. REGAN: It's in regulation?

MS. LIPSON: I don't -- I think the home care statute and the Article 28 statute are very similar, but I could be wrong.

MS. REGAN: Yeah.

MS. LIPSON: So, more to -- more to study.

DR. STRECK: Well, I just think

PHHPC - 12-6-2012 - Albany, New York

if you're a not-for-profit board member of an organization, went through the whole process of undoing your history and, you know, creating alliances that may not have been desired, and you did do that and then found that you could not do that on other grounds, it would be disconcerting, to say the least.

Other comments on any sections here?

See, Karen, I have -- I've lost my place which may be to your great advantage here, but -- oh, again, back to this limited duration operating certificate, based on the comments earlier and now these comments, I -- I really see that we are actively entering a new phase of regulation with these limited operating certificates because they're -- we're putting them in place for routine and now more specified things across the spectrum. I just want to point that out. If the Council thinks that's the best way to do business, that's fine but it is, I would suggest, a change.

Any additional comments? Hearing

PHHPC - 12-6-2012 - Albany, New York

none, John, I would entertain a motion.

DR. RUGGE: I would so move.

FROM THE FLOOR: Second.

DR. STRECK: So, the Recommendations Seventeen through Nineteen have been recommended for approval. Is there any further discussion? Hearing none, those in favor, aye?

FROM THE FLOOR: Aye.

DR. STRECK: Opposed? Thank you. Those are passed. So we are now in the final common pathway recommendations, Twenty to Twenty-three.

DR. RUGGE: It is tempting to suggest that we consider licensing a new parlor game. Instead of the Seven Dwarfs, who can name the twenty-three recommendations in order? But first we have to get there. Turning to Karen, the last few sets regarding population health and relationship to quality as a new dimension of C.O.N.

MS. LIPSON: So, this recommendation, Recommendation Twenty, begins on

PHHPC - 12-6-2012 - Albany, New York

page forty-two and it provides the following. When construction projects involving expansion of capacity or services, the C.O.N. process would include an examination of the operator's performance on quality benchmarks. So, for example, if a facility seeks to establish a new extension site, a new ambulatory surgery center, but they have very poor performance on surgery benchmarks, we might want to look at that and consider whether approval of that site is appropriate. So, not just looking at compliance with regulations and whether there have been enforcements and those enforcements have been settled, but also looking at quality performance.

The second bullet in Recommendation Number Twenty relates to physical plant oversight. This is really more of a reminder than anything else, that as we roll back certificate of need for construction projects and for primary care facilities, we need to be mindful of licensure requirements and that oversight of physical plant is an important aspect of licensure.

The third bullet is to require

PHHPC - 12-6-2012 - Albany, New York

certificate of need and licensure applicants to demonstrate that they have implemented or have a plan to implement electronic health records and to connect to the SHIN-NY. There was a lot of discussion about this requirement in the committee. There may be construction projects that are so minimal that an investment in the H.R. would be disproportionate to the project and so that requirement could be waived. There was also some discussion about highly sensitive services that raised heightened confidentiality concerns and the fact that providers of those services may not want to or be able to upload data to the SHIN-NY. And this recommendation asks the Department to work with stakeholders to develop a way to address those concerns.

There's a bullet missing. The words are here, but the actual bullet mark is missing in the third bullet. So, the last part of that bullet says require submission of SPARCS data consistent with the Affordable Care Act requirements related to race ethnicity and disability as a condition or contingency of C.O.N.

PHHPC - 12-6-2012 - Albany, New York

In order to conduct planning, we have to make sure that all of our providers are submitting their SPARCS data. So, this requirement would heighten the requirement of submitting SPARCS data.

And last but not least, the last bullet asks us to expand our public need schedules and our C.O.N. applications to solicit information concerning the ways in which projects will address priorities and focus areas in the prevention agenda.

Recommendation Number Twenty-one asks the Department to conduct a more calibrated approach to financial feasibility reviews. It asks that we focus state resources on financially weak providers while reducing administrative hurdles for stronger ones. It asks us to conduct ongoing monitoring of the financial status of hospitals and nursing homes, using standardized metrics to assess their financial performance and respond as appropriate. And it asks that C.O.N. applications submitted by financially stable hospitals based on those metrics -- and it should say nursing homes as well -- actually - - actually, I don't think it was

PHHPC - 12-6-2012 - Albany, New York

supposed to say nursing homes. Well, we'll get to that. C.O.N. applications submitted by financially stable hospitals should be subject to less scrutiny for financial feasibility.

And finally, it asks that financial reviews include the consideration of the impact of capitation and bundled payments and feasibility submissions and also provide greater flexibility in debt structures for high performing hospitals.

The last recommendation is relax the prohibition on revenue sharing among providers that are not established as co-operators. The initial version of this recommendation was broader and it included revenue sharing not just among providers, but among other types of entities and it was narrowed in the committee discussion to include just providers. Right now, if two providers want to enter into an arrangement where they are sharing revenues and that might be bundled payments or shared savings arrangements, technically, this regulation might impede that arrangement. And I think we're trying to support those types of

PHHPC - 12-6-2012 - Albany, New York

arrangements in our re-design of the health care delivery system and new payment models. So, this proposal would eliminate that barrier and it would eliminate the requirement that those providers be established as co-operators, but it would still require review and approval of the revenue sharing arrangement.

DR. RUGGE: Again, you have another set of recommendations, I think, preparing for the future. Understand we're developing new evidence base standards of care that we can monitor against those standards, that we have new information technologies which allow for coordination of care in that same kind of monitoring, further calibration of financial feasibility, and allowing a heightened level of integration including revenue sharing among co-established providers.

MS. LIPSON: I forgot twenty-three.

DR. RUGGE: Yeah, we'll --.

DR. STRECK: We still have twenty-three; right?

PHHPC - 12-6-2012 - Albany, New York

MR. RUGGE: Yes.

MS. LIPSON: Yes.

DR. STRECK: Okay. So we'll do these through twenty-two. Dr. Boufford, then Mr. Hurlbut?

DR. RUGGE: Sure, go ahead, yeah.

DR. BOUFFORD: This is a minor question, but on page forty-two, the new bullet -- that new bullet that you added, my recollection of the meeting in which this was discussed was that we were going to require a submission of all SPARCS data. And this reads as though it's only that is consistent with the A.C.A. So, I'm wondering if the language ought to say submission of SPARCS data including those consistent with the A.C.A. requirements, because otherwise it's more limited than what we've discussed?

MS. LIPSON: Okay.

DR. STRECK: Mr. Hurlbut?

MR. HURLBUT: I do think on Recommendation Number Twenty-one, the second one should say nursing homes as well. I mean, it's discriminatory. It's as simple as I can put it.

PHHPC - 12-6-2012 - Albany, New York

The other thing is -- is that I think with financial feasibility, in some areas, we need a little bit more scrutiny. And I will use as a poster child, Albany County Nursing Home. That nursing home never should have showed up, ever. We don't -- it was a financial disaster and it was brought in for political reasons. And it just -- if you're losing twenty-four million and then you're building a new one and you're going to lose fifty-four million, why are we even considering it? You know, I'm just saying in the devil in the details, again, you can't -- and if it's going to add to the Medicaid budget, the cost, I mean, some of this stuff is all right but when you look at like ten -- these greenhouse nursing homes that are ten beds and what it's costing per bed to build them and then what it costs per bed to operate them, which are financially, they're a disaster, and yet, it's going to add to the Medicaid budget. And I think that those kind of things have got to be put in here. That's why I love looking at finances because the Albany County Nursing Home didn't make it for one second. And the fact that

PHHPC - 12-6-2012 - Albany, New York

we had people from the county legislature -- Albany County Legislature that don't know how to read financial statements. We just -- those projects should just never see the light of day and I think that that -- on Recommendation Twenty-one, again, in the details, that's what we really need to do.

DR. RUGGE: It qualifies PHHPC as a safety net provider, from the court of last resort.

MR. HURLBUT: Yeah, well just -- they need to go.

DR. STRECK: Karen, could I clarify from the earlier exchange? The first bullet does say hospitals and nursing homes. The second bullet says hospitals. Is the intent to have hospitals and nursing homes in the second bullet, as well?

MS. LIPSON: No, it was not. So, let me explain the distinction and we did discuss this. Obviously, we should conduct ongoing monitoring of the financial status of hospitals and nursing homes for exactly the reason that Mr. Hurlbut suggested. We should also be doing that

PHHPC - 12-6-2012 - Albany, New York

with D and T.C.s, but I think we're not quite as far along as developing the tools to do that.

With respect to the second bullet, concerns were expressed within D.O.H. about the significant portion of nursing home revenues that are paid by State Medicaid dollars and the fact that nursing homes can experience severe financial difficulties very quickly, that a single project could upset the stability of a nursing home, and when a nursing home closes it's not just a source of health care that closes, but it's also the home of the people who live there. So, a decision was made that we should, at least for the time being, continue to review the financial feasibility of nursing home projects the way we have been.

MR. HURLBUT: Well, I don't have a problem with you looking at them and I think you should, but if you've got good operators and what they're doing is adding a program or what they're doing is re-doing their nursing home because it would cost a bloody fortune to shut it down and build a new one, that preference should be given,

PHHPC - 12-6-2012 - Albany, New York

just like hospitals, to stable nursing home operators. I mean, I don't -- what's the difference?

MS. LIPSON: I don't think this proposal was intended to give a preference to stable operators over unstable operators or vice-versa in terms of approving certificate of needs. It's -- certificates of need. It's really more about the internal process and where we focus our resources in terms of financial reviews.

MR. HURLBUT: It's -- no, that doesn't work for me. Nursing homes should be included. There's no reason they should not be included.

DR. STRECK: You have -- Mr. Hurlbut, you have two options. Among the house rules today is to propose that this be deferred for further discussion later or under the Robert's Rules, you could propose an amendment. Those are the opportunities I can afford you at the moment.

MR. HURLBUT: I would like to propose an amendment that nursing homes be put in under bullet number two, under Recommendation

PHHPC - 12-6-2012 - Albany, New York

Twenty-one.

DR. STRECK: So, there's a motion to insert nursing homes in the recommendation. Is there a second? Hearing no second, the motion fails. Is there further discussion on any of these recommendations? Dr. Sullivan?

DR. SULLIVAN: Just on Recommendation Twenty-two, the second to the last line, you have reviewed the terms, the arrangements may be shared, may be necessary. So, I'm assuming what you're saying is that when the regulations are done, you may be requiring review, but you may not be? You're leaving it up to -- am I reading that correctly?

MS. LIPSON: Yes, although I agree, it's probably not that clear. It's -- it says review of the terms of the revenue sharing arrangements and limits on percentage of revenues that may be shared may be necessary. So, reviews may be necessary, reviews and limits may be necessary. That's the intent.

DR. SULLIVAN: So there would be regulations deciding what realm of things you would

PHHPC - 12-6-2012 - Albany, New York

end up reviewing?

MS. LIPSON: Right, yes.

DR. SULLIVAN: That's what you're implying would happen? And some may not need such review?

MS. LIPSON: Right, exactly.

DR. RUGGE: The committee speculated that a ninety percent sharing of revenues, for example, would not be appropriate but did not determine the specific percentage might be the upper limit.

DR. SULLIVAN: Right. Okay. Thank you.

DR. RUGGE: Dr. Gutierrez?

DR. GUTIERREZ: Did you just change the wording there?

MS. LIPSON: No.

DR. GUTIERREZ: Okay. I'm sorry.

DR. RUGGE: No.

DR. STRECK: Are there other comments on Recommendations Twenty through Twenty-two? Hearing none, I'd entertain a motion.

DR. RUGGE: I would so move.

PHHPC - 12-6-2012 - Albany, New York

FROM THE FLOOR: Second.

DR. STRECK: So Recommendations Twenty through Twenty-two have been moved for approval with a second. Further discussion? Hearing none, those in favor of those recommendations as presented, please say aye.

FROM THE FLOOR: Aye.

DR. STRECK: Opposed? Thank you.

DR. RUGGE: We do have one more recommendation.

DR. STRECK: We have twenty-three; right?

DR. RUGGE: Yes.

DR. STRECK: We put it in the same numerical order, just to keep track, okay, so.

DR. RUGGE: How structured. This is very simple, as someone indicated earlier. This is essentially a placeholder, so that the Council can be aware that we need to monitor, perhaps ever more closely, environmental standards and protections against floods, hurricanes, and other weather and environmental disasters.

DR. BOUFFORD: I just -- I think

PHHPC - 12-6-2012 - Albany, New York

one of the problems, in retrospect, that was a significant issue and it may be implicit in construction standard was energy availability, you know, electricity, you know -- and I don't know if energy systems or something that specific to that ought to be in there because construction and environmental may or may not include any of these kind of infrastructure questions. It seems to me that was a drop-dead question for many of these places.

DR. RUGGE: All too close.

COMMISSIONER SHAH: I'm happy to comment on that. Absolutely, energy, fuel, workforce, there's a broad agenda here, and I -- you know, I'm happy to say that we will absolutely consider all of these based on the recommendations of the governor's committees and that should all fall under the purview. This is a placeholder. I'm happy to edit it, if you need, but I don't feel strongly either way.

DR. RUGGE: Yeah.

DR. BOUFFORD: I just think the limitation should just -- construction,

PHHPC - 12-6-2012 - Albany, New York

environmental, was -- would be a fear of leaving it this way, maybe other -- as other things recommended by the Governor's Taskforce, that might be good at this point, yes.

MR. STRECK: Dr. Martin?

MR. MARTIN: Right. And just to -- again, it just flog the same horse. It's only because there's no -- there's no language in addition to this that would explain that obviously we're talking our business continuity and -- and the follow-up and the like. So, I guess, if the minutes just reflect it, that would be helpful.

DR. STRECK: Mr. Kraut?

MR. KRAUT: Just to make a suggestion so maybe you can cover all these things. We can just basically say we'll work with stakeholders to review and update as necessary all standards for health care facilities to protect patients, staff, and facilities in the event of weather and flooding. So, you know, by excluding -- by not being specific, it includes everything that comes out of a good idea -- you know, no good idea will be excluded.

PHHPC - 12-6-2012 - Albany, New York

DR. STRECK: Right.

MR. MARTIN: And maybe other disasters, rather than, you know, earthquakes, other acts of God, terrorism, yada, yada, yada.

DR. STRECK: Well, we're trusting to some words, some friendly wordsmithing amendment that is -- it will be like some of our naming opportunities today, retrospective. So, we will -- we will take this motion in its spirit. Is there a second?

FROM THE FLOOR: Second.

DR. STRECK: Is there a further discussion on the motion which will be comprehensive, inclusive, and concise when it is completed?

DR. RUGGE: And final.

DR. STRECK: Right. Those in favor of the motion, please say aye.

FROM THE FLOOR: Aye.

DR. STRECK: Opposed? Thank you. So that concludes the recommendations of the planning committee. And with that conclusion, I think we can extend our thanks to the leadership of

PHHPC - 12-6-2012 - Albany, New York

the planning committee, that would be John and Karen and to all the star ward members of the planning committee. By my estimate, it was close to thirty hours of meetings for twenty-three recommendations, a very low, low productivity ratio, but nonetheless -- but nonetheless a high quality one. So, I would --.

MR. KRAUT: There was no lunch and no water.

DR. STRECK: Mr. Kraut says there was no lunch and no water, which helped their productivity ratio.

I also want to thank Dr. Boufford, Dr. Birkhead for their work and, you know, it's quite remarkable that this work has come through the Council. There are those who did the work, there are those of us who sit at meetings and take vicarious credit for the work, so we are doubly indebted. I do want to thank all of you for your patience today and your attention. This was a good meeting. These were important issues. If there are no objections, on behalf of the Council, I would wish all the best of holidays and we will

PHHPC - 12-6-2012 - Albany, New York

adjourn. Thank you.

(The meeting adjourned at 3:00 p.m.)

PHHPC - 12-6-2012 - Albany, New York

STATE OF NEW YORK
I, Howard Hubbard, do hereby certify that the foregoing was reported by me, in the cause, at the time and place, as stated in the caption hereto, at Page 1 hereof; that the foregoing typewritten transcription consisting of pages 1 through 243, is a true record of all proceedings had at the hearing.

IN WITNESS WHEREOF, I have hereunto subscribed my name, this the 11th day of December, 2012.

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Howard Hubbard, Reporter

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