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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

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

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

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

16 Mr. Loftus, please go ahead.

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

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

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

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

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

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

24 Mr. O'Leary, please go ahead.

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2 MR. O'LEARY: Thank you, Doctor.

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

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

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

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

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

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

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

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

21 Any questions from the audience?

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

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2 motion then is carried.

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

8 Mr. Gavitt, please?

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

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

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

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

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

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

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2 we have not received any comments on the proposal.

3 That concludes my presentation.

4 DR. GUTIERREZ: Thank you, Mr.  
5 Gavitt.

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

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

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

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

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

22 (Off the record)

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



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

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

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

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2 Twenty-three.

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

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

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

24 Jeff, it's your turn.

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

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

24 This is just kind of little word

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

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

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

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

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

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

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

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

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

7 DR. RUGGE: Dr. Gutierrez?

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

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

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

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

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

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

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

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



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2 MR. KRAUT: Next. Okay.

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

8 Karen?

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

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

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

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

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2 record those changes.

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

14 The second bullet remains the  
15 same.

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

24 The following paragraph begins

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2 approved passive parent relationships would be.  
3 Delete subject to a three-year time limit. Insert  
4 reviewed every three years. Delete prior to the  
5 expiration, and the remainder of that sentence.  
6 Delete the beginning of the next sentence, requests  
7 for extensions. That's deleted. Insert reviews  
8 would be. Delete the word reviewed. Based on the  
9 systems compliance record financial, delete  
10 stability. Insert management, quality of care, and  
11 evidence that the passive parent arrangement is  
12 mutually beneficial for the parent. Insert and or  
13 its affiliates. Failure to meet these standards  
14 could -- oh, sorry. Insert failure to meet these  
15 standards could result in, delete A. Insert  
16 revocation of passive parent approval or other  
17 action. Delete the next sentence which begins  
18 implementation of a plan for clinical integration.  
19 And on the next page -- oh,  
20 actually it's the same page -- affiliates with  
21 existing passive parent relationships, that remains  
22 the same until the next sentence, however existing  
23 relationships would be subject to, and delete the  
24 time limitation and. And retain review -- would be

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2 subject to review.

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

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

17 Dr. Martin?

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

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

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

6 MS. MADDEN: Sorry.

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

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

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

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

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

11 DR. RUGGE: Dr. Gutierrez?

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

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

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

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

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

7                   Howard?

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

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



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2 collaborative. All the more justifies their  
3 establishment.

4 Dr. Martin?

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

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

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

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

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

8 DR. RUGGE: Feel free.

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

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

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

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

24 Improper or illegal efforts to

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

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

20                   Yes, Mr. Kraut?

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

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

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

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

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

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

10 Dr. Gutierrez?

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

15 Ms. Waltman?

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

19 DR. RUGGE: Thank you very much.

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

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

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

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

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

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

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



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

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

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

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2 kind of thing.

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

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

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

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

24 And finally, on your newest

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

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

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

6 Mr. Heigel?

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

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

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

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

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

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

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

5 DR. RUGGE: Thank you very much.  
6 Mr. Hime.

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

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

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

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

23 Recommendation Sixteen, which is  
24 Character Incompetence for Complex Organizations



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

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

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

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

7 So with that, I appreciate  
8 your --

9 DR. RUGGE: Thank you very much.

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

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

19 MR. HIME: Right.

20 DR. RUGGE: Thank you.

21 MR. HIME: Thank you very much.

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

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

8 FROM THE FLOOR: Aye.

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

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

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

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2 conversations, so please pay attention to that.

3 There's a record of appearance

4 form for our audience that is outside the room.

5 It's required by the Joint Commission on Public

6 Ethics in accordance with Executive Law 166. We

7 would ask you to fill out that form. Thank you for

8 your cooperation in that.

9 Now I will move to our meeting,

10 which today will be a full meeting covering a

11 number of topics.

12 We will begin with the Department

13 of Health reports. We will hear from Dr. Shah.

14 Ms. Westervelt will give an update on Office of

15 Health Systems Management activities. Ms. Block

16 will report on the activities of the Office of

17 Health Information Technology Transformation. And

18 Dr. Birkhead will give a report on the activities

19 of the Office of Public Health.

20 Under the category of Public

21 Health Services, Dr. Boufford will present to

22 Council a very important result, that being the

23 prevention agenda for 2013 through 2017. And the

24 State health improvement plan for adoption, we will

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

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

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

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

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

10 FROM THE FLOOR: Aye.

11 DR. STRECK: Thank you.

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

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

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

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

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

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

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

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



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

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

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

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

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

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2 MR. STRECK: Thank you, Rick.

3 We'll now move on, beginning with a -- a series of  
4 reports. And it's a pleasure to hear from  
5 Commissioner Shah who will update the Council about  
6 the Department's activities since our last meeting.

7 Commissioner Shah?

8 COMMISSIONER SHAH: Thank you.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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



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

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

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

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

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

24                           The call centers and help lines

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

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

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

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

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

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

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

24 Other things you may not think

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

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

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

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

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

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

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

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

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

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

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



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

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

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

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

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

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

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

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

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

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

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

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

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

18 Dr. Bhat?

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

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

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

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

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

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

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

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

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

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



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

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

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

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

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

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

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

1           PHHPC - 12-6-2012 - Albany, New York  
2     in Manhattan. We continue to monitor those numbers  
3     with Greater New York and HANYS regularly. We are  
4     trying to be creative about understanding what is a  
5     real excess capacity versus, you know, you need  
6     this kind of excess capacity for preparedness.

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

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

23                    DR. STRECK: Mr. Kraut?

24                    MR. KRAUT: You know, two other

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

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

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

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

14 DR. STRECK: Dr. Strange?

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

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

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

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

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

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

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

24 COMMISSIONER SHAH: I just want

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



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

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

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

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2 and the like.

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

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

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

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

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

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

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

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

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

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

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

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

15 DR. STRECK: Questions for Ms.  
16 Westervelt?

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

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

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2 State just hovering under five hundred million.

3 And chances are before we get to the end of this  
4 year, we will meet or exceed that number.

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

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

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2 disasters and disaster response?

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

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

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

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

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



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2 agreements in place to access that information.

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

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

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2 facilitating access to key pieces of information.

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

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

24 Access to clinical information in

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

4 It's been mentioned that we're in  
5 an early flu season. We're also into the winter,  
6 which is respiratory virus season, so those --  
7 those baseline sorts of things are also going on.  
8 Part of this, I think, is getting word out to  
9 people who are in the affected areas.

10 Communication still may not be good there. We've  
11 put out and the City Health Department alerts in  
12 the last couple of days to the health providers,  
13 pretty broadly to give them information and also to  
14 have them share that information with their  
15 patients.

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



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

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

17 DR. STRECK: Dr. Strange?

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

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

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

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

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

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

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

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

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

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

13 DR. STRECK: Okay. Jo?

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

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

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

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

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

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

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

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

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

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

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

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



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

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

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

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

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

24 But for our investment in the

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

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

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

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

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

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

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

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

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

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

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

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2 to intervene at each of these levels.

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

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

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

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



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2 and participation in each of the working groups.

3 Each of them was given a template  
4 for developing their recommendations which included  
5 identifying the focus areas they would work with,  
6 the goals that they would select, measurable  
7 objectives and interventions along the health  
8 pyramid that I outlined, as well as the specific  
9 roles that each of these stakeholders should play.

10 So there were suggestions for what could the  
11 business community do in one of the priority areas.  
12 What could academia do? What could the media do?  
13 What could community based organizations do?

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

24 The -- it sort of happily at the

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

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

24                   Disparities, again, front and

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

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

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2 care delivery system.

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

6 DR. BIRKHEAD: Thanks, Dr.  
7 Boufford.

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

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

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

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

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

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

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

12 This is a five-year process of  
13 the -- of the state health improvement plan, so we  
14 set objectives for a five-year time frame, so by  
15 2017, essentially, since this is going to begin the  
16 beginning of 2013. And on average I think we  
17 came -- we -- we -- we -- it's always a challenge  
18 to pick what the target is, how much are you going  
19 to improve something, how much are -- are you going  
20 to reduce something. On average, I think these  
21 worked out to be about ten percent. For most of  
22 them as you'll see, though, we -- we actually had a  
23 little methodology and some ended up being more  
24 or -- more or less a ten percent.

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

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

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

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

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



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2 for -- for reference.

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

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

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

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

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

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

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

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

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

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

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2 them.

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

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

24 So I'm quickly going to go

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

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

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

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

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

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

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

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



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

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

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

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

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

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2 level to help make that data available.

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

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

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2 last round.

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

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

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

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

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

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

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

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

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

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

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

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2 But thanks very much for all that effort.

3 Are there questions for Dr.

4 Boufford or for other members of the committee who  
5 have labored so diligently here?

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

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

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



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

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

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

11 COMMISSIONER SHAH: Unfunded.

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

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

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

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

24 FROM THE FLOOR: Aye.

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2 DR. STRECK: Opposed? Thank you.

3 The motion passes.

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

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

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

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

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

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

14 FROM THE FLOOR: Aye.

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

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

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

12 FROM THE FLOOR: Second.

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

17 FROM THE FLOOR: Aye.

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

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

24 The emergency version of the

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

10 FROM THE FLOOR: Second.

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

15 FROM THE FLOOR: Aye.

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

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

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

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

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

12 DR. STRECK: Thank you, Dr.  
13 Gutierrez.

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

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

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2 (A luncheon recess was taken at  
3 12:38 p.m.)

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

10 Mr. Kraut?

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

24 The other thing, Mr. Chairman, we

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



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

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

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

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

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

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

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

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

21 FROM THE FLOOR: Second.

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

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2 FROM THE FLOOR: Aye.

3 DR. STRECK: Opposed? Thank you.

4 The motion carries.

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

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

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

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

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

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

7 FROM THE FLOOR: Second.

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

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

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

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

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

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

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

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

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

14 So, those in favor of the motion,  
15 aye?

16 FROM THE FLOOR: Aye.

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

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

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

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

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

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

24 Application one two two zero

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

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



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

9 Contingency number three,  
10 submission of a statement acceptable to the  
11 Department that the applicant will consider  
12 creating or entering into an integrated system of  
13 care that will reduce the fragmentation of the  
14 delivery system, provide coordinated care for  
15 patients and report to the Department and  
16 coordinated care to patients and reduce  
17 inappropriate utilization of services. The  
18 applicant will agree to submit a report to the  
19 Department beginning in the second year of  
20 operation and each year thereafter detailing these  
21 efforts and the results.

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

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

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

8 I have now the following  
9 Certificates of Amendment of the Certification of  
10 Incorporation. AIDS Community Service of Western  
11 New York to retroactively change its name to  
12 E.H.S., Inc., New York Foundation for Eldercare to  
13 change its name to the New York Foundation for  
14 Elder Care, Horizon Human Services, Inc. to  
15 retroactively change its name to Horizon Health  
16 Services, Inc., Jewish Home Foundation, Inc.  
17 changed its name to the Jewish Senior Life  
18 Foundation. I recommend approval.

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

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2 committee recommend approval.

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

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

11 FROM THE FLOOR: Second.

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

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

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

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2 projects and we do remind applicants of that  
3 obligation.

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

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

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

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

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

17 DR. STRECK: Other comments? Dr.  
18 Martin?

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

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

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2 Kraut, that's for you.

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

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

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

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

24 FROM THE FLOOR: Aye.

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2 DR. STRECK: Opposed? Thank you.

3 Okay.

4 MR. KRAUT: Thank you.

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

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

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

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

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2 and contingencies. And I so move.

3 FROM THE FLOOR: Second.

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

7 FROM THE FLOOR: Aye.

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

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

19 FROM THE FLOOR: Second.

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

23 FROM THE FLOOR: Aye.

24 DR. STRECK: Opposed? Thank you.



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2 The motion carries.

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

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

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

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

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

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

6 FROM THE FLOOR: Second.

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

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

16 MS. FULLER-GRAY: Yes, it is.

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

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

21 MS. REGAN: Change of ownership.

22 MS. FULLER-GRAY: Change of  
23 ownership.

24 MS. REGAN: And was there a look

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

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

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

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

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

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

15 MS. REGAN: Okay. Thank you.

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

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

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

11                   DR. STRECK: Sue?

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

19                   MR. COOK: If I may --?

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

22                   MR. COOK: I know.

23                   DR. STRECK: No. Okay. Go  
24      ahead.

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

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

24 FROM THE FLOOR: Aye.

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2 DR. STRECK: Opposed? Thank you.

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

7 MR. KRAUT: Health Alliance,  
8 Inc., changed name to Health Alliance Hospital,  
9 Mary's -- Mary's Avenue Campus and Health Alliance  
10 Hospital, Broadway Campus. Benedictine Hospital  
11 changed their name to the Health Alliance Hospital,  
12 Mary's Avenue Campus and Health Alliance Hospital,  
13 Broadway Campus. The Kingston Hospital changed  
14 their name to the Health Alliance Hospital, Mary's  
15 Avenue Campus and Health Alliance Hospital,  
16 Broadway Campus. And the committee recommended  
17 approval of these changes.

18 FROM THE FLOOR: Second.

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

22 FROM THE FLOOR: Aye.

23 DR. STRECK: Opposed? Thank you.

24 MR. KRAUT: Could we ask Dr.

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2 Berliner to please return into the room?

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

10 I'm just going to read the  
11 numbers and I'm not going to mention the names of  
12 the organizations. So, for these licensures it's  
13 two zero one two L, one nine four one L, one six  
14 six three L, one nine two one L, one nine eight  
15 four L, one nine seven eight L, one six nine seven  
16 L, one eight zero nine L, two zero zero two L, one  
17 nine nine seven L, two zero one four L, two zero  
18 zero three L, two zero two six L, one nine three  
19 four L, two zero four four L, one nine eight eight  
20 L, one nine nine three L, two zero two two L, two  
21 zero one one L. And the committee recommended  
22 approval with contingency. And I so move.

23 FROM THE FLOOR: Second.

24 DR. STRECK: Thank you for that



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2 numeric mastery.

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

7 FROM THE FLOOR: Aye.

8 DR. STRECK: Opposed? Thank you.

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

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

20 FROM THE FLOOR: Second.

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

23 FROM THE FLOOR: Aye.

24 DR. STRECK: Opposed? Thank you.

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

4 DR. STRECK: Thank you, Mr.  
5 Kraut.

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

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

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2 disapproves the recommendations.

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

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

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

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

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

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

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

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

21                           COMMISSIONER SHAH: Later.

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

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

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

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

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

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

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

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

8 Recommendation Three recommends  
9 the creation of eleven geographic planning regions,  
10 which are on the map behind me. As Dr. Ruge  
11 mentioned earlier, Glens Falls Hospital has asked  
12 to participate in both the Capital region and the  
13 Adirondack region. And the committee indicated its  
14 support for Glens Falls' interest in participating  
15 in two regions. Consistent with the regional  
16 health improvement collaboratives charge to conduct  
17 planning around not just health care, but  
18 population health and consistent with the  
19 increasing emphasis on ambulatory care, these  
20 regions are not principally designed around  
21 inpatient referral patterns. They are designed to  
22 take into account population health planning  
23 activities, ambulatory care planning activities,  
24 and existing health planning infrastructure as well



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2 as migration patterns for inpatient care.

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

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

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

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

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

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

14 DR. RUGGE: Discussion is very,  
15 very welcome.

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

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

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

24 FROM THE FLOOR: Second.

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

6 FROM THE FLOOR: Aye.

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

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

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

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

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

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

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

24 The licensing process for those

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

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

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

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

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

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

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

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

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



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

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

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

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

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

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

11 Comments from members of the  
12 Council? Mr. Hurlbut?

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

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

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

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

22 MR. ROBINSON: May I?

23 DR. STRECK: Yes.

24 MR. ROBINSON: So, yeah, let me

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

24                           MR. HURLBUT: And just as a

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

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

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

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

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

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

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

7 DR. STRECK: Mr. Hurlbut?

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

18 DR. RUGGE: Right.

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

24 DR. RUGGE: And we hope to have



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2 you here for those discussions.

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

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

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

15 DR. RUGGE: I would presume so.

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

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

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

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

10 DR. RUGGE: Yes.

11 DR. STRECK: Okay.

12 DR. RUGGE: Yes. Thank you,  
13 Howard.

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

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

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

15 DR. RUGGE: Yeah.

16 DR. STRECK: Thank you.

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

24 DR. STRECK: Other comments?

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2 Yes, Dr. Sullivan?

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

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

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

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

22 DR. RUGGE: Thank you.

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

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

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

10 DR. STRECK: That's right. Six  
11 to thirteen. Going, comments? John, we'd  
12 entertain a motion?

13 DR. RUGGE: I would so move.

14 FROM THE FLOOR: Second.

15 DR. STRECK: Item six to thirteen  
16 have been moved and seconded. Is there a further  
17 discussion, comments? Hearing none, those in  
18 favor, aye?

19 FROM THE FLOOR: Aye.

20 DR. STRECK: Those opposed?

21 Thank you.

22 DR. RUGGE: I would -- I would  
23 like --

24 DR. STRECK: Fourteen to sixteen?

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2 DR. RUGGE: -- I would note that  
3 we're already past the midway mark and would turn  
4 to Karen for the next three.

5 DR. STRECK: Don't get cocky.  
6 Just keep going. Okay?

7 MS. LIPSON: These three  
8 recommendations relate to our process for approving  
9 operators of health care facilities and they  
10 attempt to do a couple of things. The first one  
11 attempts to eliminate barriers to integration of  
12 systems and recruitment of experienced leadership.  
13 And the second two relate to aligning character and  
14 competence reviews with the growing complexity of  
15 health care organizations.

16 So, I'll start with number  
17 fourteen, which is rationalize taint. Taint is our  
18 colloquial term for disqualification of applicants  
19 to operate health care facilities and home care  
20 agencies. And right now we disqualified -- we have  
21 a mandatory disqualification of applicants who have  
22 recurring violations that threaten health and  
23 safety. This has created some problems in  
24 implementation as facilities and health care

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2 organizations become more complex and individuals  
3 are linked to more health care facilities and  
4 organizations, there's a greater likelihood, but  
5 they would have two or more violations of health  
6 care regulations in their background.

7 In addition, the -- because of  
8 this, this mandatory disqualification discourages  
9 experienced people or deters experienced people  
10 from going into additional health care  
11 organizations because of the fact that they are  
12 more likely to have violations in their background.  
13 So, this proposal would create a more flexible  
14 approach to disqualification. Instead of looking  
15 at two or more violations of the same regulation as  
16 the grounds for disqualification, it would look at  
17 whether or not there is a pattern or multiple  
18 pattern of or multiple violations, that evidence of  
19 failure in governance or systemic weaknesses.

20 In addition to looking at  
21 violations, this proposal would also look at  
22 satisfaction of quality benchmarks. It may be that  
23 there isn't a pattern of multiple enforcements or a  
24 pattern of or multiple enforcements but that there



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2 is abysmal performance on quality benchmarks.  
3 We've recognized that those benchmarks have yet to  
4 be adopted. Our Office of Quality and Patient  
5 Safety is developing dashboards for various  
6 health -- types of healthcare facilities and we  
7 anticipate using those dashboards to measure  
8 healthcare providers in their -- in their  
9 affiliated organizations.

10 Even if there is a pattern of  
11 enforcements, that would not trigger a mandatory  
12 disqualification under this proposal. There would  
13 a presumption of disqualification which can be  
14 rebutted under limited circumstances. Those  
15 circumstances would be the individual's role in the  
16 organization and actions to address problems, the  
17 timing of his or her involvement in the  
18 organization, recent performance, and the extent of  
19 his or her involvement in health care  
20 organizations. And this proposal would extend not  
21 just to the owners or board members of health care  
22 organizations but also the C.E.O. or C.F.O. of a  
23 facility or agency.

24 The last piece of this proposal

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2 is that the focus should not just be on  
3 individuals. If an entity is seeking to engage in  
4 an establishment action, whether it's a merger or a  
5 joint venture, the focus should be on the  
6 organization, rather than on the individuals and we  
7 should be looking at the organization's compliance  
8 and its quality performance and not whether an  
9 individual on the board or within the ownership  
10 structure has an affiliation with another unrelated  
11 facility and that unrelated facility has a poor  
12 track record. It really should be a focus on the  
13 organization that is applying to undertake an  
14 establishment action. So, that's sixteen. I'm  
15 sorry; that is fourteen.

16 Fifteen relates to character and  
17 competence reviews of not-for-profit corporations.  
18 We are seeing bigger, more complex, not-for-profit  
19 corporations. This proposal would impose new  
20 requirements on the front end of character and  
21 competence and streamline review at the back end.  
22 And what I mean by that is established  
23 not-for-profit operators would be expected to  
24 conduct a character and competence review of their

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2 own board members when the board member is  
3 appointed and the operators would be expected to  
4 update that review in the event that they're  
5 undertaking an establishment action, like a joint  
6 venture or merger.

7 And instead of the Department of  
8 Health verifying the established operator's review,  
9 the established operator would attest to that  
10 review and disclose any compliance or quality  
11 problems. And the Department would still have the  
12 prerogative to make recommendations to the PHHPC  
13 and the PHHPC would still have the prerogative to  
14 agree with or disagree with those recommendations  
15 based on the disclosures made by the established  
16 operator. So, this would not apply to new  
17 operators. This would apply to existing operators  
18 that are seeking to undertake an establishment  
19 action.

20 And then Recommendation Sixteen  
21 relates to complex proprietary organizations and  
22 new complex not-for-profit systems. Under this  
23 proposal, complex proprietary organizations -- and  
24 what I'm really talking about here are the publicly

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2   traded or private equity owned home care agencies  
3   and dialysis facilities that we permit in New York  
4   State. Right now in the homecare arena, we are  
5   required to look up and down the corporate chain at  
6   each of the entities and their principles and we  
7   are required to look at health-related  
8   subsidiaries. And the poster child for this was  
9   when we had to look at the compliance record of all  
10  Walgreen's pharmacies in the country. So, this  
11  process sometimes seems like it's not adding a  
12  whole lot of value and what we really should be  
13  looking at is the principles in the regulated  
14  entity and perhaps the parent of that regulated  
15  entity and the organization's compliance as a  
16  whole.

17                   So, this requires D.O.H. review,  
18  as we currently do, of the regulated entity and the  
19  parent. And if that parent is a holding company,  
20  we would go up the corporate chain until there was  
21  an entity that actually had some sort of activity  
22  that it engages in. And it would require an  
23  attestation by the ultimate parent concerning its  
24  controlling shareholders or members and concerning

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2 the organizational compliance record of the entire  
3 organization.

4 And then a determination could be  
5 made by the applicant and D.O.H. about whether a  
6 third party review could be substituted for D.O.H.  
7 review. That third party review could be conducted  
8 by an accrediting organization or by an auditing  
9 firm or some other credible organization that the  
10 Department approves of and that -- and that would  
11 substitute for D.O.H. review if D.O.H. agrees. We  
12 would then make our recommendation to PHHPC and  
13 PHHPC would have the prerogative to agree or  
14 disagree with the recommendation based on the  
15 attestation or review and the disclosures. That is  
16 it.

17 DR. STRECK: Okay. Thank you,  
18 Karen.

19 John, do you have any comments,  
20 other than that?

21 DR. RUGGE: No. I think, once  
22 again, now taking a looking at governance and  
23 review of character and competence is a -- is a  
24 next stop, not as a definitive final step.

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2 DR. STRECK: So, Dr. Berliner?

3 DR. BERLINER: Karen, a question  
4 about number sixteen, in my experience most,  
5 certainly not-for-profit boards, don't do what the  
6 D.O.H. would consider a character and competence  
7 review of new or potential board members. So, this  
8 is saying that the D.O.H. would ask all  
9 not-for-profits to do such a review?

10 MS. LIPSON: We would ask  
11 established health care facilities to do that  
12 review. And it has been pointed out that our  
13 Schedule Two-A, the character and competence form  
14 that we ask facilities to complete when they're  
15 undertaking an establishment action, is long and  
16 asks a lot of questions that might not add a lot of  
17 value. And we have said that we would work with  
18 stakeholders to streamline that form and make sure  
19 that the questions are targeted and that they add  
20 value to the review.

21 DR. BERLINER: And if -- and if  
22 an established organization decided to add a board  
23 member, even if that review was not positive  
24 according the standards that get developed, that

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2 would then become an issue for this -- for this  
3 committee to review?

4 MS. LIPSON: Only if they came  
5 before us with an establishment action, just as it  
6 would today.

7 DR. STRECK: Yeah. Right. So,  
8 board memberships could still have some fluidity,  
9 but it would be an establishment application that  
10 would bring this review process forward and there  
11 would have been an organizational character and  
12 competence review, presumably, on any individuals  
13 that could be applied when they came before this  
14 group. Is that correct?

15 MS. LIPSON: Can you repeat the  
16 question?

17 DR. STRECK: Probably not,  
18 actually, since it was so ill phrased. Who had a  
19 question over here? Mr. Hurlbut? Okay. I'll try  
20 again.

21 MR. HURLBUT: I'm more than happy  
22 to give you time to think.

23 DR. STRECK: Yeah, right.

24 MR. HURLBUT: On Recommendation

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2 Fourteen, one of the things I want to make -- I  
3 think it's -- again, it's the devil in the details  
4 and I don't necessarily want to change it. But for  
5 the for-profits, I wish you went from ten years  
6 back to three. Having lived through this  
7 establishment process before, some of the stuff  
8 that we've gone through as an industry really have  
9 nothing to do with resident care that we pay some  
10 fines on. It has to do with buildings and it  
11 doesn't correlate with the F TAGS right now -- you  
12 know, the federal F TAGS. You know -- you know,  
13 the state is -- interprets it -- some of them  
14 differently. And the other issue is sometimes  
15 we've -- you know, we've paid the fines and just to  
16 get it over with and done because the I.D.R.  
17 process, I mean to be thoroughly honest with you,  
18 is a joke. It doesn't work.

19 So, I.D.R., some of our issues  
20 that we have during surveys, the citations we get,  
21 it's like the wolf is in the hen house. We used to  
22 have private meetings face to face and then it went  
23 to driving to Albany and then it went to phone  
24 calls and then it went to send your letters in, to



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2 when you try to do the dispute resolution. And we  
3 don't win them and then, yet, we pay the fine. We  
4 don't agree with that, but we do it and then when  
5 we go to establishment it's held against us again.  
6 So, it's almost like double jeopardy. So, again, I  
7 think in number fourteen, when it's time, I'm not  
8 saying -- I think it's -- actually, you're moving  
9 in the right direction, is that this needs to be  
10 seriously addressed.

11 DR. RUGGE: Point well taken.

12 DR. STRECK: Mr. Kraut?

13 MR. KRAUT: Just going back to  
14 Howard's point, I think part of what we were trying  
15 to accomplish on Recommendation Sixteen, right, is  
16 we're setting a standard and basically saying that  
17 if you are going to be part of the governance of an  
18 Article 28 facility in this state, we're telling  
19 the governing authority that you have a  
20 requirement. This is the minimum standard we're  
21 asking you to do. We're asking you, it's not  
22 enough that you do business with these people, it's  
23 your brother's sister-in-law's cousin's nephew. It  
24 is the fact we need you to dig a little deeper into

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2 their background. You have to do things. You have  
3 to attest there isn't anything in that background,  
4 that when you come forward for an action that  
5 requires approval, that person would pass muster.  
6 I mean -- I mean, in essence, that's what where --  
7 and for the first time, we're still getting, you  
8 know, the stuff that Sue spoke about before and Mr.  
9 Hurlbut. You know, we're trying to understand --  
10 we've always -- this pursuit of what is character  
11 and competence and I just -- I just want to -- I  
12 think this is a good start to tell -- to deal with  
13 some of the -- you know, relieve some of the  
14 administrative burden, but to tell facilities there  
15 is a minimum requirement here, but that's it.

16 DR. STRECK: Dr. Boutin-Foster?

17 DR. BOUTIN-FOSTER: Does this  
18 include description of the process that they went  
19 through to ascertain some of this information? So,  
20 what is the process that they went through to do a  
21 character and competency review, because since  
22 we're not doing it, since the D.O.H. is not doing  
23 it, then what's the -- you know, the trail to make  
24 sure it was done appropriately?

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2 MS. LIPSON: I would expect --  
3 and these details have to be worked out, but I  
4 would expect that we would ask them to get their  
5 board appointees to complete the same form we ask  
6 new -- newly established applicants to complete.  
7 Can I just add something? In the committee  
8 meeting, Sue Regan asked that we add a sentence and  
9 I should have mentioned that because I think it  
10 goes in Recommendation Fourteen. She asked us to  
11 add a sentence, and it would probably go on page  
12 thirty-five, that further refinement is needed  
13 concerning the concept of character. Is that  
14 correct?

15 MS. REGAN: Well, I would like to  
16 go maybe a little further and just say that while  
17 we're pulling back a little bit on the tainting, we  
18 want to recommend that attention be paid to  
19 defining character. Well, let me just say we were  
20 talking earlier about -- offline, about how do you  
21 do this. And I realized that you can be a trustee  
22 of a hospital and be -- I mean there's no standard  
23 of behavior as there is for everyone from  
24 surveyors, to nurses, to architects, to engineers,

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2 where there's a standard of misconduct. There's a  
3 list in Section 8 of the Education Law, you do  
4 these things, you lose your license, but you can be  
5 a trustee of a hospital and have done any number of  
6 things. And I guess what I'm hoping is that in  
7 this whole process, we can come up with some  
8 minimal standards for that position. And I would  
9 like to somehow express that we want to look at  
10 that.

11 DR. STRECK: Other? May I try  
12 again? Under fifteen, where we -- you do the  
13 character and competence for a new board member and  
14 then the next bullet says require the operator  
15 update the review in the event of any establishment  
16 action. I mean, is that -- is that the review of  
17 that new board member? Is that the review of the  
18 entire board? I'm not quite sure what that means?

19 MS. LIPSON: So, right now, if a  
20 health care facility seeks to enter into a joint  
21 venture with another facility or a physician  
22 practice in order to establish another Article 28  
23 facility, they would have to submit to us those  
24 Schedule Two-A's of all of their board members.

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2   And we would then verify everything in those  
3   Two-A's. So, what this says is when you appoint a  
4   new board member, you have them complete the  
5   Schedule Two-A so you know that they're going to  
6   pass muster. And then if you decide you want to  
7   enter into a joint venture with another entity, you  
8   would have to update those Schedule Two-A's and  
9   it's -- even today, you would have to update them  
10  because in order to enter into the joint venture,  
11  you would have to submit them to us, but we're just  
12  asking you to update them. We're not going to  
13  verify them. So, that's the difference. You would  
14  update them and you would attest to us that you  
15  have updated them and that either they pass muster  
16  based on our standards or you've identified the  
17  following issues.

18                   DR. STRECK: This may just be  
19  grammatical, but it seems that the second clause is  
20  referring to the first and it's really referring to  
21  the entire board.

22                   MS. LIPSON: Okay.

23                   MS. REGAN: So --

24                   DR. STRECK: At least to my

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2 reading.

3 MS. REGAN: -- does that mean,  
4 Karen, that you could do, like what happened at  
5 Peninsula, where they changed the whole board and  
6 since it was not an establishment event, they  
7 didn't have to attest to the character and  
8 competence of their new board members?

9 MS. LIPSON: I think we're going  
10 to get to that in a little while.

11 DR. RUGGE: We addressed that in  
12 another recommendation.

13 MS. LIPSON: Sorry.

14 DR. RUGGE: Yes.

15 DR. STRECK: Okay. Some clarity  
16 there. Mr. Kraut has moved the recommendation,  
17 usurping Dr. Rugge's privilege --

18 MR. KRAUT: Oh, I'm sorry.

19 DR. STRECK: -- for all his good  
20 work but --

21 DR. RUGGE: No.

22 DR. STRECK: -- nonetheless, you  
23 will --

24 DR. RUGGE: No, go right -- go

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2 right ahead.

3 DR. STRECK: We've allowed Dr.  
4 Ruggie to second the motion.

5 DR. RUGGE: I will go second.

6 DR. STRECK: Okay. Well, thank  
7 you. So, we now have motions on Recommendations  
8 Fourteen to Sixteen. Is there any further  
9 discussion, comments? Hearing none, those in favor  
10 of Recommendations Fourteen to Sixteen, please say  
11 aye?

12 FROM THE FLOOR: Aye.

13 DR. STRECK: Those opposed?  
14 Thank you. Those recommendations are passed.  
15 We'll now move to Recommendations Seventeen  
16 through Nineteen.

17 DR. RUGGE: As I think everyone  
18 in the room heard this morning, the committee, only  
19 today, was able to meet to do final review and  
20 adoption by committee of recommendations regarding  
21 the passive parent paragraph. I believe everyone  
22 at the table has received revised language that was  
23 considered this morning and adopted for  
24 recommendation by the committee. And Karen then

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2 can do a very brief review of that because we've  
3 already discussed it at great length and in detail  
4 with everyone present and then we'll move onto the  
5 next recommendation or two.

6 MS. LIPSON: So, this is  
7 Recommendation Number Seventeen, align passive  
8 parent oversight with powers exerted by parents.  
9 And the amendment that everyone should have in  
10 front of them creates a sort of light review  
11 process for passive parent relationships. And it  
12 provides for a notice to the Department identifying  
13 entities involved, board members, affiliation  
14 agreement, and organizational documents when a  
15 passive parent relation -- or prior to the  
16 commencement of a passive parent relationship. The  
17 notice would be asked to -- would have to include  
18 how the proposed arrangement will benefit the  
19 health care facility seeking to affiliate the  
20 passive parent and the broader health care system.

21 The Department would have ninety  
22 days to recommend a disapproval to PHHPC. If no  
23 action were taken by the Department, the  
24 transaction could go forward. Grounds for



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2 recommending disapproval would be a poor record of  
3 compliance, integrity, financial management, or  
4 quality on the part of the passive parent or its  
5 affiliates, or lack of evidence that the passive  
6 parent arrangement would benefit the proposed  
7 affiliate as well as the parent and/or existing  
8 affiliates.

9 Approved passive parent  
10 relationships would be reviewed every three years.  
11 Reviews would be based on the systems compliance  
12 record, financial management, quality of care, and  
13 evidence that the passive parent arrangement is  
14 mutually beneficial for the parent and/or its  
15 affiliates. Failure to meet those standards could  
16 result in a revocation of passive parent approval  
17 or other action.

18 Affiliates with existing passive  
19 parents would not be required to seek the  
20 Department's approval of current relationships.  
21 So, passive parents that, today, are involved in  
22 these types of relationships would not have to come  
23 to the Department and submit a notice with a  
24 ninety-day review. However, if existing passive

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2 parents seek to affiliate with new providers, there  
3 would be a ninety-day review and they would be  
4 subject to the three-year review. And the rest of  
5 the Recommendation Seventeen is deleted.

6 Recommendation Eighteen is  
7 approve transparency of major changes in board  
8 membership. There is a requirement in our  
9 regulations that not-for-profit health care  
10 providers report to the Department on their board  
11 annually, but that process for doing so is unclear.  
12 There's no form to fill out and there's no  
13 electronic process for submitting. This  
14 recommendation is that we create a more structured  
15 process for that and also that there be  
16 notification of any change of twenty-five percent  
17 or more of the members of a facility board within a  
18 twelve-month period.

19 Recommendation Number Nineteen is  
20 strengthen the Department's authority to respond to  
21 failures in governance.

22 Am I going beyond the batch?

23 DR. RUGGE: No.

24 MS. LIPSON: Okay. Sorry.

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2 And this proposal would express  
3 the Council's support of legislation to permit the  
4 Department to appoint temporary operators of  
5 hospitals and diagnostic and treatment centers and  
6 to replace board members under extraordinary  
7 circumstances where the health and safety of  
8 patients is of concern and financial instability  
9 threatens patient care.

10 In addition, this recommendation  
11 recommends the expanded use of limited duration  
12 operating certificates where new operators are  
13 established, where new models of care are created,  
14 and where compliance or quality of care issues are  
15 identified. And the rationale there is as we move  
16 towards greater use of attestation and as we have  
17 this growing complexity of health care  
18 organizations, we may want to have a more -- a  
19 stronger way of controlling facilities that are not  
20 performing properly. So, this would create -- this  
21 would recommend expanding our use of those limited  
22 duration operating certificates. There would be  
23 expiration dates on operating certificates with  
24 greater frequency where new operators are

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2 established or where there are new models of care  
3 or issues related to compliance or quality that are  
4 identified, but that don't preclude approval of a  
5 project or an operator.

6 DR. STRECK: So, by way of  
7 summary, three recommendations, looking at improved  
8 or updated monitoring of increasingly complex  
9 health care organizations and recourse for the  
10 State, for the Department to intervene in the event  
11 of impending organizational failure.

12 DR. STRECK: Comments or  
13 questions from members of the council?

14 COMMISSIONER SHAH: So, you know,  
15 much has been discussed on the use of passive  
16 parents. And I think that we believe that it is of  
17 such significance that the Department needs to have  
18 some level of oversight of this passive parent  
19 model. I think what we've been able to achieve  
20 through the conversations in committee and  
21 elsewhere is to -- is to strike the right balance.  
22 You know, anytime you want to expand regulation,  
23 you have to think of unintended consequences. And  
24 we've had a great chance to discuss the potential

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2   for that. So, what we've come up with today is  
3   really a testament to this committee that we've  
4   been able to make sure that we get what we need out  
5   of the rules but we don't overstep our bounds, so  
6   thank you.

7                   DR. RUGGE: And the committee  
8   thanks the Commissioner for the personal  
9   involvement you've had and the monitoring you've  
10   done of us.

11                   DR. STRECK: I don't mean to be  
12   contrary. I just want to ask a question about the  
13   passive parent. It seems to me that if a  
14   not-for-profit board spends a year or so going  
15   through a process of deciding that they are willing  
16   to align and they expend hundreds of thousands of  
17   dollars in resources to effect such a change  
18   because they believe it is in the best interest of  
19   their organization, their fiduciary responsibility,  
20   and they have the corporate laws of the state that  
21   allow them to do this, I'm just curious as to our  
22   thoughts about how a regulation can disapprove such  
23   an action, in legal terms?

24                   MS. LIPSON: In the homecare

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2 arena, we have, through regulation, reviewed  
3 passive parent arrangements. And I'm not sure  
4 about the sequencing of that, you know, whether the  
5 not-for-profit corporation law comes first or  
6 whether the D.O.H. review comes first, but we do  
7 review those arrangements.

8 DR. STRECK: I think it's a  
9 question that will be answered one way or another,  
10 but I just -- I think that is an issue we have to  
11 confront about this particular approach, that we  
12 are essentially agreeing to a regulation that would  
13 supersede, what I perceive at least, I think is  
14 corporate law that is established here. So, it  
15 leaves us with some further questions perhaps  
16 and -- or more detailed answers at another date but  
17 that is -- that has been my concern about this.  
18 I'm fully cognizant of the concerns of the  
19 Commissioner and the committee, but I have  
20 expressed to the Commissioner and to this group  
21 that I think this is a question that it remains  
22 unanswered in my mind.

23 DR. RUGGE: Mr. Dering, have you  
24 had a chance to look at this?

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2 MR. DERING: I haven't looked at  
3 it but in terms of if the Department's going to  
4 regulate control of an entity, then I think it  
5 would have the authority to have requirements that  
6 are in addition to whatever exists in corporate  
7 law. So, I haven't looked at the issue, but that  
8 would be my response at this time.

9 DR. RUGGE: It sounds like that  
10 would be a next step.

11 MS. REGAN: One short answer is  
12 though it just -- it would take a statutory change.  
13 Isn't that the -- wouldn't it likely -- in home  
14 care, it's by statute.

15 MS. LIPSON: Actually, it's in  
16 regulation.

17 MS. REGAN: It's in regulation?

18 MS. LIPSON: I don't -- I think  
19 the home care statute and the Article 28 statute  
20 are very similar, but I could be wrong.

21 MS. REGAN: Yeah.

22 MS. LIPSON: So, more to -- more  
23 to study.

24 DR. STRECK: Well, I just think

1           PHHPC - 12-6-2012 - Albany, New York  
2    if you're a not-for-profit board member of an  
3    organization, went through the whole process of  
4    undoing your history and, you know, creating  
5    alliances that may not have been desired, and you  
6    did do that and then found that you could not do  
7    that on other grounds, it would be disconcerting,  
8    to say the least.

9                           Other comments on any sections  
10   here?

11                        See, Karen, I have -- I've lost  
12   my place which may be to your great advantage here,  
13   but -- oh, again, back to this limited duration  
14   operating certificate, based on the comments  
15   earlier and now these comments, I -- I really see  
16   that we are actively entering a new phase of  
17   regulation with these limited operating  
18   certificates because they're -- we're putting them  
19   in place for routine and now more specified things  
20   across the spectrum. I just want to point that  
21   out. If the Council thinks that's the best way to  
22   do business, that's fine but it is, I would  
23   suggest, a change.

24                           Any additional comments?   Hearing



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2 none, John, I would entertain a motion.

3 DR. RUGGE: I would so move.

4 FROM THE FLOOR: Second.

5 DR. STRECK: So, the

6 Recommendations Seventeen through Nineteen have

7 been recommended for approval. Is there any

8 further discussion? Hearing none, those in favor,

9 aye?

10 FROM THE FLOOR: Aye.

11 DR. STRECK: Opposed? Thank you.

12 Those are passed. So we are now in the final

13 common pathway recommendations, Twenty to

14 Twenty-three.

15 DR. RUGGE: It is tempting to

16 suggest that we consider licensing a new parlor

17 game. Instead of the Seven Dwarfs, who can name

18 the twenty-three recommendations in order? But

19 first we have to get there. Turning to Karen, the

20 last few sets regarding population health and

21 relationship to quality as a new dimension of

22 C.O.N.

23 MS. LIPSON: So, this

24 recommendation, Recommendation Twenty, begins on

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2   page forty-two and it provides the following.  When  
3   construction projects involving expansion of  
4   capacity or services, the C.O.N. process would  
5   include an examination of the operator's  
6   performance on quality benchmarks.  So, for  
7   example, if a facility seeks to establish a new  
8   extension site, a new ambulatory surgery center,  
9   but they have very poor performance on surgery  
10  benchmarks, we might want to look at that and  
11  consider whether approval of that site is  
12  appropriate.  So, not just looking at compliance  
13  with regulations and whether there have been  
14  enforcements and those enforcements have been  
15  settled, but also looking at quality performance.

16                   The second bullet in  
17  Recommendation Number Twenty relates to physical  
18  plant oversight.  This is really more of a reminder  
19  than anything else, that as we roll back  
20  certificate of need for construction projects and  
21  for primary care facilities, we need to be mindful  
22  of licensure requirements and that oversight of  
23  physical plant is an important aspect of licensure.

24                   The third bullet is to require

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2 certificate of need and licensure applicants to  
3 demonstrate that they have implemented or have a  
4 plan to implement electronic health records and to  
5 connect to the SHIN-NY. There was a lot of  
6 discussion about this requirement in the committee.  
7 There may be construction projects that are so  
8 minimal that an investment in the H.R. would be  
9 disproportionate to the project and so that  
10 requirement could be waived. There was also some  
11 discussion about highly sensitive services that  
12 raised heightened confidentiality concerns and the  
13 fact that providers of those services may not want  
14 to or be able to upload data to the SHIN-NY. And  
15 this recommendation asks the Department to work  
16 with stakeholders to develop a way to address those  
17 concerns.

18 There's a bullet missing. The  
19 words are here, but the actual bullet mark is  
20 missing in the third bullet. So, the last part of  
21 that bullet says require submission of SPARCS data  
22 consistent with the Affordable Care Act  
23 requirements related to race ethnicity and  
24 disability as a condition or contingency of C.O.N.

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2 In order to conduct planning, we have to make sure  
3 that all of our providers are submitting their  
4 SPARCS data. So, this requirement would heighten  
5 the requirement of submitting SPARCS data.

6 And last but not least, the last  
7 bullet asks us to expand our public need schedules  
8 and our C.O.N. applications to solicit information  
9 concerning the ways in which projects will address  
10 priorities and focus areas in the prevention  
11 agenda.

12 Recommendation Number Twenty-one  
13 asks the Department to conduct a more calibrated  
14 approach to financial feasibility reviews. It asks  
15 that we focus state resources on financially weak  
16 providers while reducing administrative hurdles for  
17 stronger ones. It asks us to conduct ongoing  
18 monitoring of the financial status of hospitals and  
19 nursing homes, using standardized metrics to assess  
20 their financial performance and respond as  
21 appropriate. And it asks that C.O.N. applications  
22 submitted by financially stable hospitals based on  
23 those metrics -- and it should say nursing homes as  
24 well -- actually - - actually, I don't think it was

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2 supposed to say nursing homes. Well, we'll get to  
3 that. C.O.N. applications submitted by financially  
4 stable hospitals should be subject to less scrutiny  
5 for financial feasibility.

6 And finally, it asks that  
7 financial reviews include the consideration of the  
8 impact of capitation and bundled payments and  
9 feasibility submissions and also provide greater  
10 flexibility in debt structures for high performing  
11 hospitals.

12 The last recommendation is relax  
13 the prohibition on revenue sharing among providers  
14 that are not established as co-operators. The  
15 initial version of this recommendation was broader  
16 and it included revenue sharing not just among  
17 providers, but among other types of entities and it  
18 was narrowed in the committee discussion to include  
19 just providers. Right now, if two providers want  
20 to enter into an arrangement where they are sharing  
21 revenues and that might be bundled payments or  
22 shared savings arrangements, technically, this  
23 regulation might impede that arrangement. And I  
24 think we're trying to support those types of

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2 arrangements in our re-design of the health care  
3 delivery system and new payment models. So, this  
4 proposal would eliminate that barrier and it would  
5 eliminate the requirement that those providers be  
6 established as co-operators, but it would still  
7 require review and approval of the revenue sharing  
8 arrangement.

9 DR. RUGGE: Again, you have  
10 another set of recommendations, I think, preparing  
11 for the future. Understand we're developing new  
12 evidence base standards of care that we can monitor  
13 against those standards, that we have new  
14 information technologies which allow for  
15 coordination of care in that same kind of  
16 monitoring, further calibration of financial  
17 feasibility, and allowing a heightened level of  
18 integration including revenue sharing among  
19 co-established providers.

20 MS. LIPSON: I forgot  
21 twenty-three.

22 DR. RUGGE: Yeah, we'll --.

23 DR. STRECK: We still have  
24 twenty-three; right?

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2 MR. RUGGE: Yes.

3 MS. LIPSON: Yes.

4 DR. STRECK: Okay. So we'll do  
5 these through twenty-two. Dr. Boufford, then Mr.  
6 Hurlbut?

7 DR. RUGGE: Sure, go ahead, yeah.

8 DR. BOUFFORD: This is a minor  
9 question, but on page forty-two, the new bullet --  
10 that new bullet that you added, my recollection of  
11 the meeting in which this was discussed was that we  
12 were going to require a submission of all SPARCS  
13 data. And this reads as though it's only that is  
14 consistent with the A.C.A. So, I'm wondering if  
15 the language ought to say submission of SPARCS data  
16 including those consistent with the A.C.A.  
17 requirements, because otherwise it's more limited  
18 than what we've discussed?

19 MS. LIPSON: Okay.

20 DR. STRECK: Mr. Hurlbut?

21 MR. HURLBUT: I do think on  
22 Recommendation Number Twenty-one, the second one  
23 should say nursing homes as well. I mean, it's  
24 discriminatory. It's as simple as I can put it.

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2     The other thing is -- is that I think with  
3     financial feasibility, in some areas, we need a  
4     little bit more scrutiny. And I will use as a  
5     poster child, Albany County Nursing Home. That  
6     nursing home never should have showed up, ever. We  
7     don't -- it was a financial disaster and it was  
8     brought in for political reasons. And it just --  
9     if you're losing twenty-four million and then  
10    you're building a new one and you're going to lose  
11    fifty-four million, why are we even considering it?  
12    You know, I'm just saying in the devil in the  
13    details, again, you can't -- and if it's going to  
14    add to the Medicaid budget, the cost, I mean, some  
15    of this stuff is all right but when you look at  
16    like ten -- these greenhouse nursing homes that are  
17    ten beds and what it's costing per bed to build  
18    them and then what it costs per bed to operate  
19    them, which are financially, they're a disaster,  
20    and yet, it's going to add to the Medicaid budget.  
21    And I think that those kind of things have got to  
22    be put in here. That's why I love looking at  
23    finances because the Albany County Nursing Home  
24    didn't make it for one second. And the fact that



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2 we had people from the county legislature -- Albany  
3 County Legislature that don't know how to read  
4 financial statements. We just -- those projects  
5 should just never see the light of day and I think  
6 that that -- on Recommendation Twenty-one, again,  
7 in the details, that's what we really need to do.

8 DR. RUGGE: It qualifies PHHPC as  
9 a safety net provider, from the court of last  
10 resort.

11 MR. HURLBUT: Yeah, well just --  
12 they need to go.

13 DR. STRECK: Karen, could I  
14 clarify from the earlier exchange? The first  
15 bullet does say hospitals and nursing homes. The  
16 second bullet says hospitals. Is the intent to  
17 have hospitals and nursing homes in the second  
18 bullet, as well?

19 MS. LIPSON: No, it was not. So,  
20 let me explain the distinction and we did discuss  
21 this. Obviously, we should conduct ongoing  
22 monitoring of the financial status of hospitals and  
23 nursing homes for exactly the reason that Mr.  
24 Hurlbut suggested. We should also be doing that

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2 with D and T.C.s, but I think we're not quite as  
3 far along as developing the tools to do that.

4 With respect to the second  
5 bullet, concerns were expressed within D.O.H. about  
6 the significant portion of nursing home revenues  
7 that are paid by State Medicaid dollars and the  
8 fact that nursing homes can experience severe  
9 financial difficulties very quickly, that a single  
10 project could upset the stability of a nursing  
11 home, and when a nursing home closes it's not just  
12 a source of health care that closes, but it's also  
13 the home of the people who live there. So, a  
14 decision was made that we should, at least for the  
15 time being, continue to review the financial  
16 feasibility of nursing home projects the way we  
17 have been.

18 MR. HURLBUT: Well, I don't have  
19 a problem with you looking at them and I think you  
20 should, but if you've got good operators and what  
21 they're doing is adding a program or what they're  
22 doing is re-doing their nursing home because it  
23 would cost a bloody fortune to shut it down and  
24 build a new one, that preference should be given,

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2 just like hospitals, to stable nursing home  
3 operators. I mean, I don't -- what's the  
4 difference?

5 MS. LIPSON: I don't think this  
6 proposal was intended to give a preference to  
7 stable operators over unstable operators or  
8 vice-versa in terms of approving certificate of  
9 needs. It's -- certificates of need. It's really  
10 more about the internal process and where we focus  
11 our resources in terms of financial reviews.

12 MR. HURLBUT: It's -- no, that  
13 doesn't work for me. Nursing homes should be  
14 included. There's no reason they should not be  
15 included.

16 DR. STRECK: You have -- Mr.  
17 Hurlbut, you have two options. Among the house  
18 rules today is to propose that this be deferred for  
19 further discussion later or under the Robert's  
20 Rules, you could propose an amendment. Those are  
21 the opportunities I can afford you at the moment.

22 MR. HURLBUT: I would like to  
23 propose an amendment that nursing homes be put in  
24 under bullet number two, under Recommendation

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2 Twenty-one.

3 DR. STRECK: So, there's a motion  
4 to insert nursing homes in the recommendation. Is  
5 there a second? Hearing no second, the motion  
6 fails. Is there further discussion on any of these  
7 recommendations? Dr. Sullivan?

8 DR. SULLIVAN: Just on  
9 Recommendation Twenty-two, the second to the last  
10 line, you have reviewed the terms, the arrangements  
11 may be shared, may be necessary. So, I'm assuming  
12 what you're saying is that when the regulations are  
13 done, you may be requiring review, but you may not  
14 be? You're leaving it up to -- am I reading that  
15 correctly?

16 MS. LIPSON: Yes, although I  
17 agree, it's probably not that clear. It's -- it  
18 says review of the terms of the revenue sharing  
19 arrangements and limits on percentage of revenues  
20 that may be shared may be necessary. So, reviews  
21 may be necessary, reviews and limits may be  
22 necessary. That's the intent.

23 DR. SULLIVAN: So there would be  
24 regulations deciding what realm of things you would

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2 end up reviewing?

3 MS. LIPSON: Right, yes.

4 DR. SULLIVAN: That's what you're  
5 implying would happen? And some may not need such  
6 review?

7 MS. LIPSON: Right, exactly.

8 DR. RUGGE: The committee  
9 speculated that a ninety percent sharing of  
10 revenues, for example, would not be appropriate but  
11 did not determine the specific percentage might be  
12 the upper limit.

13 DR. SULLIVAN: Right. Okay.

14 Thank you.

15 DR. RUGGE: Dr. Gutierrez?

16 DR. GUTIERREZ: Did you just  
17 change the wording there?

18 MS. LIPSON: No.

19 DR. GUTIERREZ: Okay. I'm sorry.

20 DR. RUGGE: No.

21 DR. STRECK: Are there other  
22 comments on Recommendations Twenty through  
23 Twenty-two? Hearing none, I'd entertain a motion.

24 DR. RUGGE: I would so move.

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2 FROM THE FLOOR: Second.

3 DR. STRECK: So Recommendations

4 Twenty through Twenty-two have been moved for

5 approval with a second. Further discussion?

6 Hearing none, those in favor of those

7 recommendations as presented, please say aye.

8 FROM THE FLOOR: Aye.

9 DR. STRECK: Opposed? Thank you.

10 DR. RUGGE: We do have one more

11 recommendation.

12 DR. STRECK: We have

13 twenty-three; right?

14 DR. RUGGE: Yes.

15 DR. STRECK: We put it in the  
16 same numerical order, just to keep track, okay, so.

17 DR. RUGGE: How structured. This  
18 is very simple, as someone indicated earlier. This  
19 is essentially a placeholder, so that the Council  
20 can be aware that we need to monitor, perhaps ever  
21 more closely, environmental standards and  
22 protections against floods, hurricanes, and other  
23 weather and environmental disasters.

24 DR. BOUFFORD: I just -- I think

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2     one of the problems, in retrospect, that was a  
3     significant issue and it may be implicit in  
4     construction standard was energy availability, you  
5     know, electricity, you know -- and I don't know if  
6     energy systems or something that specific to that  
7     ought to be in there because construction and  
8     environmental may or may not include any of these  
9     kind of infrastructure questions. It seems to me  
10    that was a drop-dead question for many of these  
11    places.

12                   DR. RUGGE: All too close.

13                   COMMISSIONER SHAH: I'm happy to  
14    comment on that. Absolutely, energy, fuel,  
15    workforce, there's a broad agenda here, and I --  
16    you know, I'm happy to say that we will absolutely  
17    consider all of these based on the recommendations  
18    of the governor's committees and that should all  
19    fall under the purview. This is a placeholder.  
20    I'm happy to edit it, if you need, but I don't feel  
21    strongly either way.

22                   DR. RUGGE: Yeah.

23                   DR. BOUFFORD: I just think the  
24    limitation should just -- construction,

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2 environmental, was -- would be a fear of leaving it  
3 this way, maybe other -- as other things  
4 recommended by the Governor's Taskforce, that might  
5 be good at this point, yes.

6 MR. STRECK: Dr. Martin?

7 MR. MARTIN: Right. And just  
8 to -- again, it just flog the same horse. It's  
9 only because there's no -- there's no language in  
10 addition to this that would explain that obviously  
11 we're talking our business continuity and -- and  
12 the follow-up and the like. So, I guess, if the  
13 minutes just reflect it, that would be helpful.

14 DR. STRECK: Mr. Kraut?

15 MR. KRAUT: Just to make a  
16 suggestion so maybe you can cover all these things.  
17 We can just basically say we'll work with  
18 stakeholders to review and update as necessary all  
19 standards for health care facilities to protect  
20 patients, staff, and facilities in the event of  
21 weather and flooding. So, you know, by  
22 excluding -- by not being specific, it includes  
23 everything that comes out of a good idea -- you  
24 know, no good idea will be excluded.



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2 DR. STRECK: Right.

3 MR. MARTIN: And maybe other  
4 disasters, rather than, you know, earthquakes,  
5 other acts of God, terrorism, yada, yada, yada.

6 DR. STRECK: Well, we're trusting  
7 to some words, some friendly wordsmithing amendment  
8 that is -- it will be like some of our naming  
9 opportunities today, retrospective. So, we will --  
10 we will take this motion in its spirit. Is there a  
11 second?

12 FROM THE FLOOR: Second.

13 DR. STRECK: Is there a further  
14 discussion on the motion which will be  
15 comprehensive, inclusive, and concise when it is  
16 completed?

17 DR. RUGGE: And final.

18 DR. STRECK: Right. Those in  
19 favor of the motion, please say aye.

20 FROM THE FLOOR: Aye.

21 DR. STRECK: Opposed? Thank you.  
22 So that concludes the recommendations of the  
23 planning committee. And with that conclusion, I  
24 think we can extend our thanks to the leadership of

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2 the planning committee, that would be John and  
3 Karen and to all the star ward members of the  
4 planning committee. By my estimate, it was close  
5 to thirty hours of meetings for twenty-three  
6 recommendations, a very low, low productivity  
7 ratio, but nonetheless -- but nonetheless a high  
8 quality one. So, I would --.

9 MR. KRAUT: There was no lunch  
10 and no water.

11 DR. STRECK: Mr. Kraut says there  
12 was no lunch and no water, which helped their  
13 productivity ratio.

14 I also want to thank Dr.  
15 Boufford, Dr. Birkhead for their work and, you  
16 know, it's quite remarkable that this work has come  
17 through the Council. There are those who did the  
18 work, there are those of us who sit at meetings and  
19 take vicarious credit for the work, so we are  
20 doubly indebted. I do want to thank all of you for  
21 your patience today and your attention. This was a  
22 good meeting. These were important issues. If  
23 there are no objections, on behalf of the Council,  
24 I would wish all the best of holidays and we will

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2 adjourn. Thank you.

3 (The meeting adjourned at 3:00

4 p.m.)

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2 STATE OF NEW YORK

3 I, Howard Hubbard, do hereby certify that the foregoing  
4 was reported by me, in the cause, at the time and place,  
5 as stated in the caption hereto, at Page 1 hereof; that  
6 the foregoing typewritten transcription consisting of  
7 pages 1 through 243, is a true record of all proceedings  
8 had at the hearing.

9 IN WITNESS WHEREOF, I have hereunto  
10 subscribed my name, this the 11th day of December, 2012.

11 \_\_\_\_\_  
12 Howard Hubbard, Reporter

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