ANGEL GUTIERREZ: Good morning.

[Good morning]

ANGEL GUTIERREZ: Good morning. My name is Angel Gutierrez. I'm the chair of the Codes Regulations and Legislation Committee and we're beginning our meeting now. We have four regulations on the agenda, and we're going to alter the order a bit. Moving on with what was meant to be the third item but becomes the first one is an amendment to the section 405.4 of title 10 regarding hospital sepsis protocols and Dr. Angelotti from the Office of Quality and Patient Safety from Albany will explain. Please Dr. Angelotti, go ahead.

MARIETTA ANGELOTTI: Hi. I am here to discuss a minor change or clarification to the definition of severe sepsis for pediatrics and the sepsis regulations. We've heard from some critical care and other pediatric specialists that there was possibility for confusion in understanding what we meant by severe sepsis for pediatrics, which tends to be a more complicated definition than in adults. So we're asking to change the definition from, "for pediatrics severe sepsis shall mean sepsis plus two organ dysfunctions or acute respiratory distress syndrome" to "for pediatrics severe sepsis shall mean sepsis plus one of the following: cardiovascular organ dysfunction or acute respiratory distress syndrome or two or more dysfunctions." And this latter definition is consistent

with the international pediatric sepsis consensus conference definitions for sever sepsis in pediatrics has been approved, reviewed as accurate by the pediatric critical care specialists.

ANGEL GUTIERREZ: Is that it?

MARIETTA ANGELOTTI: Yes.

ANGEL GUTIERREZ: Thank you very much.

MARIETTA ANGELOTTI: Thank you.

ANGEL GUTIERREZ: Any questions or comments from committee? Anybody from the public that wishes to speak on this regulation? If not, I'll move on to the next presenter. Is Dr. Dennison there?

BARBARA DENNISON: Yes I am.

ANGEL GUTIERREZ: OK. Dr. Dennison will be – from the Division of Chronic Disease Prevention will discuss an amendment to section 12.3 of title 10 regarding administration of vitamin K to newborn infants. Dr. Dennison, please go ahead.

BARBARA DENNISON: OK. So what we're proposing to do is to change two things in the regulation. The original regulation was in 1997 and there's been no attempts to change it since then, and what it requires is that vitamin K be given to newborns, and currently the language requires that the vitamin K be given within one hour of birth, and we have received numerous requests to change this because the one hour requirement is not supported by any scientific evidence and we have provided evidence. For example, the American Academy of Pediatrics specifically states that injections and including vitamin K should be withheld until the mother gives the first breast feeding, and this is the big problem. It interferes with that initial skin to skin contact of the mother and the baby and with that initial breast feeding. In addition, the Canadian's recommend six hours and there is no other state in the nation that recommends one hour. It's really – there's no reason to have the one hour. The other change – so, I'll just continue – the only other change is that the regulation says, "natural vitamin K" and there's no natural vitamin K available. So we removed that to make it more consistent with what is available, and it says (parental) dose and the only recommended way to administer it is intramuscular. So we made that recommendation to change as well. We have strong letters of support from expert pediatric hematologists, (anatologists) as well as

advocacy organizations and have received five letters and they are all supported in the public comment period.

ANGEL GUTIERREZ: That's it?

BARBARA DENNISON: That's it.

ANGEL GUTIERREZ: Thank you very much Dr. Dennison. Any questions or comments from committee? Any questions or comments from the public? If not I will move on then to what is in the agenda the last item, but will adequate it to the current needs. It concerns control of STD and amends part 23 of title 10. Mr. O'Connell and Ms. Muse are here, and they will, they are from the Agency and Bureau of STD Prevention and Epidemiology and they will present. Please go ahead.

DAN O'CONNELL: All right. Good morning everybody. So, earlier this year there were major changes to article 23 of the public health law which is the STD control provisions and it's title one. And the changes that you see before you in terms of amendments to part 23 are really to make the regulations consistent with the statute. So there are a number of areas that were specifically addressed in the amendments here. The first is one that will basically modernize the language. There are a number of cases in which there were mentions of venereal

disease, for instance, so that was modernized and standardized just to talk about sexually transmitted diseases.

The second piece is that the regulations as amended would allow for billing for STD diagnosis and treatment by local health departments. That's not something that was previously allowed, but there are provisions in here that would protect individuals and make sure that if somebody didn't want to provide third party billing information that they would not be required to do so as a condition for treatment. There are also provisions – one change to the expedited partner therapy – the statute itself needed to be changed because that was going to be sunsetting this year, so that was changed in statute. But within the regulations the only change was to add HIV as a contraindication for expedited partner therapy.

The next piece was there is reference in the regulations that recognizes the fact that many counties provide STD diagnosis and treatment as required under the regulations through contract rather than directly, so this recognizes that that in fact, is the case. And finally, there is a new section that was added in around minors, so there was already language in the statute that addressed minors, and this does two things; it provides additional protections to minors in terms of billing records that might be generated because of them accepting diagnosis and treatment of STDs, and there's another provision that allows for prevention treatment to be provided to minors

who come in, who are either infected or exposed to an STD. We've worked very closely with the, with NYSECHO of these regulations, on the amended regulations, and they've been very supportive of the changes that I've addressed.

ANGEL GUTIERREZ: Thank you Mr. O'Connell. Ms. Muse. Are there any questions or comments from members of the Committee? Is there any member of the public that would like to address this recommendation? This – is Mr. Kissinger in Albany? I don't hear you. Mr. Kissinger?

MARK KISSINGER: Yes, I'm here. Can you hear me now?

ANGEL GUTIERREZ: Yes. OK. So, the first – this was supposed to be the first item in the agenda. We are going to end with this. It amends part 425 of title 10 of New York Codes Rules and Regulations and concerns adult day healthcare programs and managed long term care. Mr. Kissinger from the Division of Long Term Care is in Albany and will present the overview. Go ahead, please.

MARK KISSINGER: Yes, thank you very much. So this regulation is amendment to 425 which is regulations governing the operation and payment of adult day care programs and residential care facilities. The purpose of these amendments is

to really -- these amendments were asked for by the adult healthcare council and the crux of the amendment is to enable such to contract and work effectively with plans and care coordination model.

As we're moving from a fee-for-service to a managed care approach in the Medicaid program, these regulations provide flexibility for the adult day healthcare programs to offer what's called the hybrid model, which would mean that they could roll both adult day healthcare recipients and also recipients of what's now known as social daycare services. So there's amendments in 425 and other different sections that basically tries to allow the healthcare models to offer this hybrid model and with this hybrid model the adult day healthcare programs can respond to the evolving move to managed long term care in the area.

So, I know, I also know that were' getting a lot of comments on these regs and there's probably good potential that there will be some amendments to the regs or some modifications. We're also working with our partners at the State Office of the Aging. We have some comments as well on the regs. So, (just wanted to say that to the Council) there's a possibility these will be amended or changed, but we wanted to present the regs because they're out for public comment.

ANGEL GUTIERREZ: Thank you Mr. Kissinger. Any comments or questions from the Committee? We have two people who called ahead to speak on these regulations. I will now ask Christine Fitzpatrick, director of Adult Day Healthcare Council to come to the table to address the Committee please.

CHRISTINE FITZPATRICK: Thank you for the opportunity to speak. I very much appreciate it. I would like to say that these proposed regulations are as Mr. Kissinger stated, they are in response to the Medicaid redesign team and to the expansion of managed care in New York State, and this is something that we initiated but we have worked cooperatively with the Department on these regulations and with other stakeholders throughout New York State including managed care entities.

I'm going to try to be brief. I will say that adult day healthcare programs provide services to the chronically ill, the disabled, the frail elderly, folks with Alzheimer's, dementia. They have been doing this since the 1960s. They have a full range, they do this in a congregate setting sponsored by nursing facilities. They are certified by the Department of Health. They are subject to a survey process, and they have this full range of services from—it's very much a nurse-centered program. There were always nurses responsible for adult day healthcare programs. They provide a full range of services from skilled services to services like therapeutic recreation, case

management, monitoring, meals. They have for years in an adult day healthcare program, they have for years provided both services that would be characterized as social day level services as well as adult day health services. That's what adult day health is. It's a combination of both types of services, so they're very practices at doing this in a very sophisticated and regulated environment. The issue is that based on the way the regulations are constructed now, that anybody who comes to an adult day healthcare program, they have to be – and this will continue, they will be required to have a full range of services available to them, certainly, but right now what happens when people come to an adult day healthcare program, they have to be – they must need the skilled services and they must have the entity that is paying for the services must be charged an all-inclusive rate. The problem that we were encountering with managed long term care programs where they were saying to us, we don't need on every single day a person does not need this full range of skilled services on every single day that they come to you, and neither do we want to pay for the all-inclusive rate because, for example, we do not need to pay you for case management if we are doing that ourselves. Bu the current regulations do not allow us to unbundle the package of services, neither does it allow us to unbundle the rate. So what these regulations allow programs to do is to adjust to the current situation and to provide – we say in

situations where people were coming to us one day a week for a whole package, the whole package of services including the skilled services, but then going to a different location for social day level services, which we could provide in any event, but which managed long term care plan wanted to pay for that package rather than the full package on that given day. We think that's fragmented care. We don't think that that's good for the registrants. What we're trying to do is maintain these people in the programs where they can get a continuity of care, where managed long term care plans can work with one provider rather than two, and thus better manage the care that's being provided to individuals. And to do it in an environment where the program is certified, where the level of staffing – the kinds of staff that work with people in adult day healthcare programs now and also in the future under these proposed regulations will be the same level of staffing that it's always been; the same kinds of staffing which are certified nursing assistants, nurses, physical occupation and speech therapists certified activity professionals, that kind of thing. And there will also be a whole, in the proposed regulations, the thing that does not change is that the program overall continues to be subject to the quality assurance provisions that have always been in place in adult day healthcare programs to the maintenance of records that has always been required in adult day healthcare. That does not change. The only thing that does

change is that the individual, the services that the individual can receive are tailored to their particular needs based on a collaborative effort between the adult day healthcare program itself, and the managed long term care plan that referred then, and then the managed long term plan or care coordination model will be charged on any given day for the package of services that they believe the individual needs, rather than the whole inclusive package.

So, that's the way the regulations will work. That's their intention. And I thank you for allowing me to speak.

ANGEL GUTIERREZ: Thank you Ms. Fitzpatrick. Are there any other comments or discussion from the Committee or council members? If not, the next speaker is Elizabeth Geary, President of the New York State Adult Day Services Association. Ms. Geary, please.

ELIZABETH GEARY: Thank you. Good morning. I'm also, in addition to being president of New York State Adult Day Services, the director of Community Program Center of Long Island, and operate a social model adult day program. And I appreciate greatly the opportunity to talk to you about the proposed regulatory changes to the adult day healthcare program to create a hybrid model.

First, let me give you a brief description of what the social model is. Social model adult day services are generally small, specialized and structured programs designed to support the physical, mental, social, and emotional functioning of frail older adults and those with a cognitive disorder. Historically the majority of participants in social model programs have been those who have Alzheimer's or related dementia, the huge percentage is that group of people. Social model programs have also been proven to delay and even avoid placement in even more costly institutional settings. We have the following concerns with the proposal as written. First and foremost, the State Office for the Aging has regulations that govern social model programs to ensure high quality optimal participant-centered outcomes. The proposed regulatory change does not state that these effective and time-tested regulations will be followed. The Department of Health requires that Medicaid managed long term care plans contract only with social model programs that adhere to and are in compliance with the (NYSOFA) regulations. By not requiring that NYSOFA regulations be followed, this proposal creates a set of two rules for social model programs, and perhaps some confusion about the importance of the NYSOFA regulations as the overarching requirement for social model programs. The proposal suggests a mechanism for slots to be filled, rather than describing a program model that should be implemented.

Second, we believe there is some ambiguity in relation to the assessment of individuals who might be classified as social participants in the regulation as written. The proposal indicates that the assessment is done by the MMLTC and it does not specifically direct the staff of the hybrid model to conduct an individualized assessment that would be used to determine a specific plan of care for that individual within the program. The internal assessment and individualized care plan, we believe, is critical to ensuring that this particular individual is served in the daycare program and that they will receive core and perhaps some optional services to ensure optimal outcomes. We cannot overstate the importance of this issue. It is especially critical in relating to the Alzheimer's and dementia specific population. The Alzheimer's Association national model of activity based Alzheimer's care provides that program participants are assessed based on their strengths, interests, and needs whereby activities are designed and implemented based on those particular participants in the program on any given day. Studies have shown that a therapeutic environment and a low staff to participant ratio are critical to the behavior management of this disease. The therapeutic value of placing these individuals in the context of a program that has increased it's capacity by a full 30 percent is questionable. NYSADS recommends that the NYSOFA regulations and standards that govern social adult daycare programs be incorporated into the DOH

proposed regulations related to adult day healthcare programs and the hybrid model. We believe that this will ensure that the goals of the MRT are realized and that patient-centered care is provided in the most appropriate and least restrictive environment. Again, I thank you so much for your listening.

ANGEL GUTIERREZ: Thanks Ms. Geary. Any discussion from committee or council members? Anybody else from the public who would like to speak on this provision? If not, this finishes our agenda, and I will entertain a motion to adjourn. Thank you. Meeting is adjourned. And we hand it over to you with four minutes left.

WILLIAM STRECK: We will begin the Public Health and Health Planning Council Committee, or council meeting in two and a half minutes. You are free till then.

…take their seats, we'll begin this meeting of the Public Health and Health Planning Council after that extensive break.

So, I'm Dr. William Streck, the Chair of the Public Health and Health Planning Council, and I have the privilege of calling the meeting to order. Welcoming all of you, members of the Council, and Commissioner Shah. I would like to remind council members, staff, and the audience that our meeting is subject to the open meeting law. The webcast may be accessed at the Department of Health's website. And they are available no later

than seven days after the meeting for a minimum of 30 days thereafter. We do have some ground rules for the Council. We have synchronized captioning, so it is important for that reason that people not talk over one another. It's also courteous to do that. And so, when you speak, we would ask that you provide your name and identify yourself and the first time you speak. The microphones are hot. They pick up all conversations and so the, turn your mics off when you are not speaking. There's a form that needs to be filled out. I would remind the audience as you enter the meeting room it's required by the joint commission on public ethics in accordance with executive law section 166. This form is also posted on the Department of Health's website under the Certificate of Need process. Thank you for your cooperation in filling out the form.

I'd now like to provide a brief overview of today's meeting. We've had a preview of the regulation discussion. Dr. Gutierrez will lead regulations. The discussion of the regulation and codes committee. We will have Department of health reports from Dr. Shah. Dr. Birkhead will be joining us in Albany and give a report on the activities of the Office of Public Health. Under the category of Public Health Services, Dr. Boufford will update the Council on the important work of the Committee on Public Health. And under health policy Dr. Rugge will update members of the Committee on health planning activities. We will then move to the project review

recommendations and establishment actions. Mr. Kraut will lead those discussions with that committee. Prior to that Mr. Kraut will present for adoption the Ad-hoc advisory committee report on Environmental and Construction Standards. The final report and recommendations following extensive study of this topic after the hurricane. And then we will move to the project review and establishment actions with doctor – Mr. Kraut leading that discussion.

I would remind members of the Council and most of our guests that we organize our CON applications by batching, so that we can be effective in our disposition and discussion. We also make note of the fact that if there are conflicts or interests in any of the applications these need to be noted. And I would just take a moment to make sure that the members of the Council have so noted to our secretary.

Comments there? If not, then I would like to move to an expression on the part of the Public Health and Health Planning Council, a resolution of appreciation to acknowledge the years of dedication that Susan Regan devoted to the Public Health Council and the Public Health and Health Planning Council. She has truly been a historical icon of these councils. On behalf of the Council, Jeff Kraut and I have signed a resolution of appreciation for Susan’s 18 years of service on these councils as a citizen of New York, and I would like to read that resolution of appreciation.

"Whereas Susan G. Regan has served with distinction on the New York State Public Health Council from December 12 1995 to November 30, 2010, and the Public Health and Health Planning Council from December 1 of 2010 to June 20 of 2013 and whereas Ms. Regan during her time as a member of the Public Health Council has honorably served many years as chair of the Committee on establishment of healthcare facilities whereas Ms. Regan during her tenure as a member of the Public Health and Health Planning Council served on the Committee of Establishment and Project Review, public health and health personnel interprofessional relations devoting considerable amount of time and SAGE council to the Department of Health's health planning efforts and whereas in serving in this capacity she has made countless contributions to improving New York State's health care delivery system and to furthering the improvement of public health for the citizens of New York State and whereas the members of the Public Health and Health Planning Council of the State of New York do hereby do express and acknowledge her unstinting, selfless and valuable service to the Council for 18 years of remarkable public service. Therefore, now let it be resolved that members of the Public Health and Health Planning Council convey to Ms. Regan our esteemed admiration and appreciation for her instrumental role in enhancing the health and wellbeing of all who reside in the State of New York. And be it further resolved that members of the Public Health and

Health Planning Council do hereby extend their gratitude to Susan G. Regan for her committed service to the Council and send her our best wishes for many years of health, happiness, and professional achievement."

And we offer this on behalf of the entire Council. Our deep appreciation to Susan for her sustained and significant contributions. So, is Sue here? She's not. We will note that, and I think we all are deeply appreciative and recognize the commitment and the intensity of commitment that Susan brought to our discussions. So, we are grateful.

So, Susan is no longer part of our Council, and I have to move on to announce the fact that Dr. Sullivan will be leaving our Council because of the exciting news that she has been nominated by Governor Cuomo to serve as the Commissioner of the Office of Mental Health. So, our congratulations to you.

[applause]

On behalf of the Council we do wish to express our appreciation to you for your time and dedication. We will given time for preparation, provide you a resolution of appreciation as well, but we are just not known for the alacrity of our political responses. So, the timing of the Governor's nomination is great news for the Office of Mental Health where as many of us know the centers of excellence strategy and a whole new world awaits New York State. So that is now under Dr. Sullivan's aegis and we can take some confidence in the fact

that we have that kind of leadership. So, thank you and the best of luck.

I just – moving to more mundane and pedestrian but nonetheless important topics, I just want to comment a little bit on the correspondence policies with the Council. We have trouble, not corresponding with one another but dealing with the correspondence which comes our way. And there's a sense on all our parts that we want to be informed, but we want to be fair and both receiving and considering information, and not engaged in 11th hour debates when more thoughtful consideration would be to everyone's advantage. So we have a policy regarding acceptance of public correspondence, but in light of recent events I have requested the department staff to revise the guidelines for observers for full Public Health and Health Planning Council meetings and the guidelines for committee observers and participants, adding a provision on policies for council members accepting written correspondence in regard to any applications that may come before us. So I just think we need to, it's a minor point, but we'll just ask the Department to give us some guidelines on how we will handle correspondence in terms of timing and the nature of such correspondence. This is not an imposition on the Council, this is a request to the staff to present to the Council some suggestions for considerations at the December meeting. Everyone OK with that

approach? OK. So, our first unanimous action today. Let's move on.

And with that, let's go to a second one. Let's approach the minutes of the last meeting. Are there any questions or concerns about the minutes from the Council meeting of August 1. May I have a motion to accept those minutes? Moved and seconded. Discussion? Hearing none, those in favor, aye?

Aye.

Thank you. The next order of business is the adoption of the 2014 Public Health and Health Planning Council meeting dates. Those have been provided to everyone. I beg your pardon? They were in the agenda materials. So, what I would suggest is that we adopt and you adapt. So, may I have a motion to accept the dates? Moved and seconded. Discussion? Hearing none, those in favor, aye?

Aye.

OK. Thank you. Now, moving one. We'll return the chair to Dr. Gutierrez to give a report on the Codes, Regulations, and Legislation Committee.

ANGEL GUTIERREZ: Thank you Mr. Chair. The Codes, Regulation, and Legislation Committee reviewed four regulations earlier this morning. None were on for adoption. The first item on the agenda concerned adult day healthcare programs and managed long term care plans. This measure specifies that the managed long term care plan or care coordination model that refers an enrollee to an adult day healthcare program will be responsible for meeting certain requirements that are currently the responsibility of the adult day healthcare operator with the intent of avoiding duplication of services. It clarifies the full range of adult day healthcare services available to the managed long term care plan and care coordination model enrollees with a medical need for such services, but allows them to order less than such full range based on an enrollees individual medical needs as determined the comprehensive assessment performed. They can enter into reimbursement arrangements with the adult day healthcare program that takes into account that program registrants receipt of less than the full range of services. The proposal also allows residential healthcare facilities to offer a hybrid model in which individuals requiring adult day healthcare services and individuals requiring only social adult day care services to both receive services in the adult day healthcare program space. Mr. Kissinger noted that the Department is receiving a lot of

comments regarding this proposal and we will evaluate all of the comments before this measure is brought back for adoption.

The second item amended provisions regarding administration of vitamin K to newborn infants. This measure will increase from one to six hours, the timeframe after birth where an attending physician, a licensed midwife, a registered professional nurse or other licensed medical professionals attending a newborn must assure administration of a single intramuscular dose of vitamin K. The intent is to remove a barrier to mothers completing the first breast feeding.

The third item in the agenda proposes -- third item presented proposed amending the hospital sepsis protocol provisions. This proposal amends the pediatric definition for severe sepsis at the request of pediatric specialists to assure absolute consistency with established definitions in order to avoid any possible confusion on the part of hospitals and clinicians. Where the current definition states that for pediatric severe sepsis shall mean sepsis plus two organ dysfunctions or acute respiratory syndrome. The proposed definition will state that for pediatrics severe sepsis is defined as sepsis plus one of the following; cardiovascular organ dysfunction, or acute respiratory distress syndrome, or two or more organ dysfunctions. The fourth and last item on the agenda was a proposal regarding control of STD. This regulation would modernize, repeal and modify relevant sections of title 10

NYCRR part 23, control of sexually transmitted diseases to be consistent with and in conjunction with amendments contained in the 2013-2014 enacted state budget. It adds provisions that allow health districts to seek third party reimbursement for services to the greatest extent possible providing however, that no board of health local health officer or other municipal health officer shall request to require that such coverage or indemnification be utilized as a condition of providing diagnosis or treatment services. That, Mr. Chairman, concludes my report. Thank you very much.

WILLIAM STRECK: Can you give us a rough outline of when these will come back for our action, each of those?

ANGEL GUTIERREZ: I assume that it will be at least another meeting or two. Do we have any comments from Albany on this regard?

WILLIAM STRECK: OK. Well, at least one more and perhaps more. I'm just trying to get a sense of our building backlog here. OK. Thank you. It's now my pleasure to welcome Dr. Shah, and to ask for his comments on the State of the State.

NIRAV SHAH: Thank you Dr. Streck. Good morning. Thank you all for joining us. We witnessed a major mile stone two

days ago with the launch of our New York State Health Benefit Exchange. We live in exciting times, and this has gotten a lot of attention nationally for our efforts to build the Exchange which all started, actually not that long ago when Governor Cuomo issued an executive order that lead to the creation of our Exchange. Planning is still going on. We have over 450 navigators helping folks enroll in the Exchange and yet the overwhelming response has blown away all our models of interest in this Exchange. On our first day we had over 10 million visits to the website. We've now reached over 30 million visits to the website. At any given second if you look on the Exchange there are over 9000 people actively logged on to the website. This has led to some delays and, but it's a good thing. It shows that people are excited. It shows that people want high quality health insurance. And it's not just the uninsured who are logging on, but it's also the currently insured who are looking and saying, maybe I need to reevaluate my options and find a better plan for myself. So, to date we've fielded over 10,000 calls with our call center. The most common question relate to tax benefits, but I assume that that will also evolve over time. We are actively every night taking the Exchange offline and working between 11PM and 8AM to update capacity, increase the flow-through and efficiencies with major upgrades planned through the weekend as well, and my – well, our initial expectations were that by the end of the enrollment period which

goes through March 31 of 2014, so we still have lots of time to enroll, there's no need to all sign up today, we expect over a million people to sign up for the Exchange. And again, to emphasize the fact that there is no need to sign up today. If you want, you can sign up as late as December 15 of this year and still be enrolled in a plan that starts January 1. If you have all you paperwork in order and you are eligible and all things go. So, we've had a few challenges there. We have a few challenges elsewhere but we're very excited, and I think that you will continue to see increasing performance and some of the stories that come out. I spoke with this woman, Ebonica in our call center, and she was talking about a 39 year old gentleman from Queens who called up. He's a father of two daughters and his wife's not well and he was looking to sign up for the Exchange and this was just the only hope he had. And these stories are going to come out in force 5000fold, 10,000fold over the next few weeks and months. A very exciting time for New York.

As I mentioned, we have a few other challenges that we're facing. Let's start in Brooklyn where our borough's hospitals have been making headlines. As you know, two hospitals in Brooklyn, the Long Island College Hospital in Cobble Hill and Interfaith Medical Center in Bedford Sty are in danger of closing. For years these hospitals have dealt with declining revenues, poor management and high volumes of Medicaid patients.

at Interfaith we've been exploring any and all financial opportunities to try to preserve emergency and outpatient services and as of now the vital access provider application and ultimately the Medicaid waiver are the only remaining sources of funds to assist with the transition and possible restructuring. And the fate of Litch remains unknown. Though there is talk that it may be taken over by another hospital and turned into a large outpatient center. You know, none of this should come as a surprise. We were warned two years ago that closings were imminent unless there was drastic restructuring of the borough's hospitals, yet nothing was done, and now hanging in the balance are the borough's 2.5 million residents, 20 percent of whom live below the poverty line. It's their health and safety that must take priority in this discussion about the fate of Brooklyn's hospitals and the State is trying to find ways to replace services lost by the closure of either or both facilities. You know, the borough has added 25 new outpatient centers in the last two years. That is clearly not enough. The challenges in Brooklyn will continue and the Department will continue to persist in looking for all possible solutions. One thing is certain; we have the health and safety of our community first and foremost in our minds as we proceed, and keeping New Yorker's healthy is always a priority especially as we stand here at the start of another flu season.

Speaking on flu, for the State's health workforce doctors, nurses, therapists, even volunteers, all of those involved in providing patient care this flu season brings with it a new mandate. As always, we are urging healthcare professionals to get a flu shot. Studies show that a flu shot is still the most effective means for protecting yourself and your family from the flu. But if you decide that you don't want to get a flu shot or you can't get a flu shot for any reason, and you work in a healthcare setting where your oath is to first do no harm, it is your ethical mandate and now the State's mandate that you must wear a surgical mask. Hospitals' will be held accountable for making sure their employees follow this rule. Just as they are regarding other patient safety regulations. You know, if you work in healthcare, you have annual TB screenings, you have documentations for MMR status in other areas. So this is just an extension of something that we in healthcare are already used to.

So you may ask why the new rule. Well, certainly it is the healthy thing to do. The ethical thing to do. As caregivers of vulnerable patients, vulnerable immunocompromised patients don't always take to the flu shot as well as healthy folks. So, the flu shot is less effective in those we're providing care for than in ourselves. So, to protect our patients better, we need to increase that rate which was well south of 50 percent last

year. Well fewer than 50 percent of healthcare workers who get their annual flu shots. We need to protect patients better.

So I ask that you consider this. I think that making yourself vulnerable to the flu, even if you're going to work and you don't know you have it is completely counter to the obligations you have to your patients. We're hoping that this year we will see large increases in vaccination rates and certainly we'll be protecting our patients despite that with the masks. We're also looking in other areas where we need to expand our role, and this is a federal question here with the role of regulatory protection against the latest trend in smoking, which is e-cigarettes. Recent research by the Centers for Disease Control and Prevention show that the use of e-cigarettes among middle and high school students doubled in 2011-2012, and today 1.78 million youths have now tried them. We're concerned that these youths are using e-cigarettes as an onramp to cigarette smoking, and unless something is done to stop these trends, we will erase decades of efforts to reduce tobacco use and create a new generation of youth addicted to nicotine. We're also concerned because e-cigarettes are being heavily promoted and marketed as a healthier alternative to traditional cigarettes. You know, it might be true that they're less harmful than tobacco cigarettes, but there is absolutely no evidence that e-cigarettes help people quit at a faster rate or that they are safer than nicotine replacement therapies such as patches or

gum. Anecdotally we see that people use e-cigarettes as bridges to smoking in areas where they can't smoke. What concerns us is that the illusion of these products are somehow safer, will actually even invite former smokers to start smoking once again. Just as worrisome is the fact that many who are "vaping" and that's a new word I learned today which is the term for smoking e-cigarettes, like vapor, "vaping" are doing so in public places that ban cigarettes. That's really going to erase all of the hard fought victories we've had in promoting cleaner indoor air. It's our hope that the FDA will tighten up their regulations on e-cigarettes and treat them as the health hazard that they are. We are actively working with college campuses and other areas that have policies against the use of cigarettes to explicitly include e-cigarette bans in all of their literature and regulations and materials, and hopefully we can catch this before this becomes yet another behemoth industry with power to sway public opinion in ways that we know are not helpful.

We're organizing a few interesting events in the coming months. I wanted to let you know the Department of Health is organizing two events in December that may be of interest to the broader public as well. The first is a population health summit organized by Dr. Birkhead and Dr. Gestin and others in the Department of Health. This will be an all-day event in New York City at the New York Academy of Sciences on December 3. The event brings together state and national leaders for a

discussion on the role of public health along with other sectors in our efforts to improve population health. The keynote speaker of the event will be Dr. Thomas Freedan, the Director of the Centers for Disease Control and Prevention. Dr. Jo Ivey Boufford, President of the New York Academy of Medicine and Dr. Jeffrey Levy, Executive Director of the Trust for America's Health. That will fill up fast. I suggest you go online and register soon. Shortly after that on December 18 we will be hosting our first ever health code-a-thon co-sponsored by the New York Health Foundation at Rensselaer Polytechnic Institute, RPI. This will be as part of Governor Cuomo's December 16 innovation week. More details are forthcoming, but the two-day event organized by health brings together public health partners, health technology experts, and coders for sessions on how to use health data off of our healthdata.ny.gov website to create apps and websites and other views of the data that will benefit health. The code-a-thon is the first phase of a larger health innovation summit, and it will be followed by a three to six month event called the New York State Health Innovation Challenge, that we hope will result in additional applications. This will be open not just to RPI in person, but across the world with large prizes as well. And I think that this will really allow for consumer engagement in ways that we don't expect the Department of Health to have that expertise. Our first goal will be to create apps and products and webpages that

link people to the places in their communities, to improve physical activity, access to high quality affordable healthy food, and ultimately reduce the risk for obesity and diabetes for this first effort. We're also co-sponsoring a third event. This third event is going to be in November. It's being co-sponsored by the United Hospital Fund, the Primary Care Development Corporation, and the New York State Chapter of the American College of Physicians on patient-centered medical homes. We will have a conversational roundtable between providers and payers to discuss how New York State can accelerate the advanced primary care development model and payment reform using collaborative multipayer efforts. Part of that will certainly include the use of health data which will allow us to improve practices, evaluate progress, and inform efforts to enhance population health. And we are lucky in New York to have several multipayer efforts across the State. We also have legislation in New York State that effectively deals with potential antitrust issues that surround multipayer arrangements. Ultimately we want to disseminate widely and integrate successfully these multipayer programs and take them from the test phase to business as usual throughout New York State.

For that November conference we'll be joined by colleagues in the Department of Financial Services and the Office of Civil Service Employees health program, and want to deliver a

consistent and targeted message to payers and providers that regarding our vision of healthcare transformation and a fundamental focus on the triple aim, advancing primary care as the means to do that.

Related, we are going to be submitting a state health innovation plan to CMMI at the end of the year, and it will discuss our vision for healthcare in New York over the coming five years. This will include payment and delivery system reform and innovations. Ultimately we are going to be competing. This will be due December and then at another RFA will come out, this will lay the foundation for a response to probably a February RFA from the feds which may result in a $60 million award to New York State to advance primary care, collaborative care, and many other models.

I want to congratulate Health Research Incorporated who just received a $4.5 million grant from the U.S. Department of Health and Human Services, the Centers for Medicare and Medicaid services, and the Center for Consumer Information and Insurance Oversight. This $4.5 million grant is a two-year grant that started actually September 30. It will allow the Health Department and the State Department of Financial Services to improve the way we review health insurance premiums in New York State. It will enable us to use the robust all-payer claims database sources so that we can actually synthesize quality patient safety cost and efficiency metrics when we look at

healthcare premiums. It will also allow us to create a consumer portal using input from consumers and stakeholders to publish health pricing data, so New Yorkers can make smart healthcare decisions based on quality and costs. In addition to the creation of a public website so that data visualization, analytics, and report generation will be easy to make healthcare prices transparent and accessible. These are big deals. And it will ultimately contribute to what we hope to do in New York; improved health for all New Yorkers.

Together with the new Exchange, these new regulations, these new grants, we're working hard on many fronts. I'd like to end by acknowledging Bob Welch who is now our new Deputy Director of Hospital and D&TC Services. I think he may be in Albany. I don't see him. Waive if you're there. OK. And that concludes my report.

WILLIAM STRECK: Thank you Commissioner. Questions for the – comments for the Commissioner? Mr. Hurlbut.

ROBERT HURLBUT: I understand about your concerns about the e-cigarettes, but these one thing I think you need to know. As far as the long term care industry, you know, I'm suggesting you be very, very careful, because we're admitting residnets out of the hospital that most nursing homes – I won't speak for New York City but in upstate and Rochester I will – we don't admit

smokers. Because it's a problem. And has been a problem. And so there's a lot of backup of these types of residents in hospitals. And there's some behavioral issues usually associated with it too, so these e-cigarettes we've been trying on a very minute basis. I'm talking, I've admitted about four of them just to try it because the hospitals beg me to do it. And this is about three months ago. And it's actually working. So whatever you want to do with the youth and stuff like that, it's up to you, but please don't mess with the long term care industry, because it's a way for these people to be in a surrounding where it's appropriate and it's working for them. So I would just be very cognizant of any changes you want to make. Please consult the long term care industry because it's helping a population that normally would be backed up and costing the state a fortune.

NIRAV SHAH: Thank you for your observation. I agree that with any policies there may be unintended consequences. But by far the biggest unintended consequence of e-cigarettes is addicting a new generation of youth, so we have to approach this aggressively but thoughtfully.

WILLIAM STRECK: Mr. Kraut.

JEFF KRAUT: Commissioner, when you made reference to Long College and Interfaith, you spoke about resting and the status of the waiver. Is there an update of where we are with the waiver?

NIRAV SHAH: So, we're working very hard with the White House to seal the deal with the waiver. I think everyone at some level understands the importance of the waiver. They may not understand the urgency of the waiver. And so our goal on all fronts from hopefully all stakeholders is that the message needs to be New York State needs it's waiver not just someday, but it needs it by the end of this calendar year. If we go into the next calendar year, not only are those institutions at risk, but many other problems across the North Country and other parts of the system that will rely on the waiver for that transition will be at high risk of failure. So our goal is to get the waiver by the end of this calendar year. Certainly the highlight, the headline happens to be the Brooklyn hospital situation, but that is just one part of a larger transformation effort that's needed and can only occur with the waiver by this calendar year.

JEFF KRAUT: And the other question I have is you made also reference to the all-payer claims database. Any idea when that might go live and be available to the policy makers?

NIRAV SHAH: So, the question related to the all-payer database. We have actually had funding for the all-payer claims database through exchange establishment grants so the funding is there, the legislation is there, and Pat Ruhan and his Office of Quality and Patient Safety has taken the lead in building it. They are actually building it as we speak. Our goal is that by next summer it will be at least major parts of it will be up and running for internal use. Obviously, in parallel, Michael, is to see how we can expend broader use beyond the Department of Health and DFS to others. Part of that $4.5 million grant that we just received will allow us to engage in those conversations and planning and access issues for others in the healthcare delivery system to appropriately use parts of that.

GLENN MARTIN: Thank you. So, yesterday and the day before Dr. Brown and I spent our lives up in Albany at the newly constituted Behavioral Health Services Council, advisory council. One of the issues that came up there of course is the integration of that, those services within the larger body of services provided here. And in passing they had mentioned that the (O) agencies had met with you or spoken with you about implementing the vaccination issue – flu vaccine issue outside of the private hospitals that were regulating and back into other state agencies and the like. Can you just give us a brief

update on where we stand on that implemented throughout the State?

NIRAV SHAH: Yes, I spoke with the other commissioners on a call yesterday or the day before on what we can do beyond the purview of the Department of Health. So, for example, facilities licensed exclusively as article 31 facilities are not subject to this regulation. But remember, the purpose of this legis – this mandate is actually to improve the culture of care. It is obviously to protect our care givers and their families and extend flu vaccination as well as a secondary benefit, but it's really about culture change. So our goal is, and Justin Pfeiffer from the Division of Legal Affairs in the Department of Health has reached out to counsels in other agencies, in the other O agencies to work on similar policies for article 31 facilities and all other care settings to extend this mandate through regulation. It's – you may argue, do we need to do this in places where you have young healthy people getting substance abuse treatment? Well, again, remember, this is about the culture of care. And there should never be anyone who gets the flu from a care provider. That is the ethical basis for why we believe this policy should extend across all healthcare facilities, all healthcare settings across the State of New York, and we will be working through regulation to continue to be consistent in our policies across the State. It is not about

being punitive. It is not about penalizing folks who don't for one reason or another meet these needs right away. It's about working with our partners in the healthcare delivery system, staff at all levels, to understand where they are, what they can do to protect their patients and ultimately achieve those rates of vaccination and masking that will protect patients consistently.

WILLIAM STRECK: Mr. Fensterman.

HOWARD FENSTERMAN: Good morning, Commissioner. You had mentioned, going back to the e-cigarettes, that an issue or you discussed the smoking of these in public places. Is there any evidence that the Department's aware of that that is deleterious to the public self in any manner?

NIRAV SHAH: The jury is still out. There haven't been those long term studies or any studies that I'm aware of beyond what the CDC has published on their website related to the health effects of 'vaping' but the reality is that there may be. We don't know. Just because it has only nicotine, while relative to the other ingredients in a regular cigarette, we don't know. And the jury is still out. So to the extent that we do know that there are least four other unintended consequences, bridging smokers to allow them to continue to

smoke despite clean air, indoor air act, allowing this as an onramp to teenagers and others preventing folks from quitting, and starting people who had already quit back onto nicotine addiction, there are clear evidence on those four fronts of the negative effects of vaping. We just think that it should be held to the same standard as cigarettes.

WILLIAM STRECK: Ms. Rautenberg.

ELLEN RAUTENBERG: Dr. Shah, there's good news story coming out of our navigator program. Like all other navigators we couldn't get on to the website on the first day, but we had a record day enrolling Medicaid clients the old fashioned way from electronically to HRA. But it seems that all the excitement brought out people who were eligible for regular Medicaid, not expanded Medicaid, thinking that they weren't eligible. Probably because they had low wage jobs. So it was very exciting for us.

NIRAV SHAH: That's a great story. I'd love to hear more about the numbers and all, and we'll follow – more and wow, that's just fantastic. You know, there will be many stories like that. The website has been continually improving. I know that if you're going in through the small business side it's a much faster experience than if you're going through the

individual side, and we're working constantly around the clock to get it up to where we know we need it to get to.

WILLIAM STRECK: Dr. Bhat.

DR. BHAT: Thank you. Dr. Shah, I would like to go back to Brooklyn

I know the area that you're talking about. In four mile radius you have eight hospitals, and two of them are failing. And always I wonder, I've spent most of my adult life in hospitals. Something that really is not very clear to me that every hospital would like to have every service, rather than just say, there are eight hospitals in a four mile radius, one of them could be for OB, could be for psych, somebody else probably could specialize in physiatry. I do know know – when I'm talking to the CEOs of many of these hospitals they believe that there's not much leadership that's coming in from Albany for them to go in that direction. Recently I think (HHC) signed a contract with outside lab to provide all the lab services. I think I thought that was a great idea because you don't have to have a lab full fledged lab in every hospital. You could probably provide only the essential things that you need. …can be outsourced or somebody else. What are the hospital Is there any way in which Albany can provide some kind of leadership to go in that direction? I think in the Berger

Commission there were some recommendations. And the second point that I would like to make is that in the last decade or so 11 hospitals in New York City area have closed. All except one, large that has graduate medical education programs. They're gone. This month of October they start calling for interviews. I get a lot of calls from people saying that they need help. Where are those residencies? Where are they going? We need primary care physicians. If they're not in New York City, they will never establish their practice. I just want you to comment on these two things.

NIRAV SHAH: Thank you. You know, we've been trying hard using different models from this administration on how to address Brooklyn's problem. Obviously the second Berger Commission was yet another attempt to allow the community to be a partner in understanding their needs and their solutions. The most recent effort that may be positive relates to the waiver. Again, we've put in requests for $25 million for regional planning in our waiver application, and whether or not that's the best way, we realize that with money things happen more than with just suggestions or you know, partnerships that you think you should get together amongst yourself. You're absolutely right, that what Brooklyn needs is transformation. That the old model of these towers that all provided all services have not met the needs of the community. They've not expanded in primary

care and behavioral health and other real needs of the community in meaningful ways on their own. And real collaboration, deep collaboration, conversations that go beyond just the service line have to happen. That can happen and be facilitated by a regional planning process. We've seen, for example, in Rochester the years of the Finger Lakes HSA and CTAB and other results lead to the highest quality, lowest cost for Medicare in the country. Didn't happen overnight. It happened over decades. To the extent that we don't have decades in Brooklyn, we're trying to accelerate using all means possible. The transformation of these services, no one wants to see the catastrophic collapse of a hospital, and yet when you're losing tens of millions of dollars a month in each institution that is failing, that's a very steep hill to climb. And our goal is to climb it or hang on until we can try to transform these systems to actually meet the needs of Brooklyn residents. Regional planning is one example. We've been in constant conversations with the leadership of not only the hospitals but of the FQHCs and primary care and behavioral health providers because we know that the old model has failed us.

LAWRENCE BROWN: Commissioner, I want to thank you for your continued leadership. Clearly your report reflects that. And I just have two matters. One is a follow up to the issue that Dr. Martin raised, and we were really interested in ways in

which those facilities, those agencies can help to facilitate this culture change. So to the extent to which they are embraced, we remove the issue about the stigma that may be unintentionally still placed or reinforced. So in that respect we want to salute you for continue to collaborate with the institutes, agencies, to be able to do so.

I have another questions though that you may not be able to answer today, but I'd like to give this so we can have follow-up. As you know, the New York State Justice Center has come into operation since, I guess it's June 30. And it's interesting to me that the focus is on agencies where the concern is about protecting vulnerable populations. And I'm not really clear to the extent to which agencies that are licensed by the Department of Health would not fall under that same purview. I mean, a patient who's in the hospital certainly is vulnerable. A patient in some of our other healthcare facilities are certainly vulnerable. So it'd be useful if you could share with us at some future meeting what is in place to protect those populations as well. Again, so we erase the unintentional stigma that the old agencies may be receiving because of the fact that that was the initial focus.

NIRAV SHAH: Yes. Thank you for your question, and it is probably time for an update from the Justice Center, and perhaps we can invite their executive director to provide an update to

this council. We've been involved with the Department of Health, certainly Keith's service and Mark Kissinger have been the leads from our end meeting regularly about, not just the other O agencies but nursing homes and other facilities and their role in the justice center. So, we'll provide an update.

WILLIAM STRECK: Further comments or questions? Well, I think it's clear that the Council is going to have a front row seat on a whole series of unintended consequences that cover a wide range of activities across our state. So, those are topics that will come back in different ways, I think, to our deliberations. Thank you. Thank you Commissioner.

Now, I'll turn to Dr. Birkhead in Albany for the report of the Office of Public Health.

GUS BIRKHEAD: Can you hear me OK, Dr. Streck?

WILLIAM STRECK: Yes, we can, Gus.

GUS BIRKHEAD: Great. Great. Thanks very much. I'll be brief. The Commissioner actually covered a number of things that I was going to talk about, and Dr. Boufford to follow me will also update you, but briefly on the Prevention Agenda, a lot of activity has been going on. County health departments and hospitals are actively engaged in their local planning

processes. Those reports and plans are due to the state in mid-November. We've been providing technical assistance to them and we've also engaged with New York Health Foundation, and Dr. Boufford will describe in her remarks some very good news from the -- for funding available, funding prevention agenda and community projects that are going to go forward.

The Commissioner mentioned the new healthcare regulation around the flu shots, and I know the Council's familiar with this since you adopted the regulation that we were putting into place, but just to update you on that, we have held multiple webinars with different sectors that are affected by this, nursing homes, et cetera, and really had great engagement from the statewide organizations that represent the different affected provider groups. So we have, I think, these webinars are archived on our website so that they can be viewed again, and I think we're getting some very good feedback in terms of how this is going to be rolling out. We do plan to do our first survey of the affected institutions on, between November 1 and November 15, the survey instrument will be open on the web for all the affected facilities to report back their vaccination coverage levels. At that point I think we'll have some idea, initial idea of the impact of this. We'll survey again at the end of the flu season to see what the final, what coverage levels are and compare it with previous years. As you know in the past, last year, for example, in hospitals less than half of

employees were vaccinated for flu. So, these efforts are underway. As Dr. Shah mentioned, we are convening the other state agencies. We have also within the State Health Department applied the same rule as a matter of personnel policy to our staff who are regularly in hospitals, and we will be basically implementing the same requirements for our own staff.

Also, then finally, just briefly to update you, Dr. Shah mentioned the population health summit on December 3. I hope you've all received a save-the-date notice for this summit. We hopefully within the next week will get out an official invitation to the meeting that will include information about how to register. We will be opening up a website for people to register for the conference. It's going to be limited to roughly 200 participants in person. We are planning, however, to webcast the summit and so those who are not able to travel to the city or able to get free will be able to view it on line, full video is what we're planning to do there.

So, I think those are the updates that I have, so I'll pass it back to you, Dr. Streck.

WILLIAM STRECK: Questions or comments for Dr. Birkhead. Mr. Fassler.

MICHAEL FASSLER: Yes, two questions; any predictions in terms of this flu season? And also anything on the Middle East Virus?

GUS BIRKHEAD: So, predictions on the flu season are fraught with difficulty. I wouldn't hesitate – I mean I don't think I can really make a prediction, so I think we'll just have to see. We are opening up our surveillance system on October 1, so we're now going to be putting out weekly reports and be tracking this, but I don't think we have any advanced information. Very hard to predict what's happening with the flu season.

The Middle Eastern Virus, the virus continues to percolate at a low level, I would say. Overseas, we have been getting information now that as they are looking more widely among people with less severe illness, they are finding evidence of people who have been exposed to this virus. So as happens with any emerging virus I think the initial cases it appears to be severe because you're just seeing the tip of the iceberg. So it may be that there's more exposure to this virus than we were aware of, and it still remains to be seen what the severity profile is, what proportion of infected people truly get severe illness. Clearly it can cause severe illness. Fortunately it does not appear to have sustained person-to-person transmission so we remain vigilant for here, but have not seen any cases

coming to this country, and my sense is that things have quieted down in terms of the number of new cases being seen in the Middle East. There has been some progress in defining where the virus is coming from, and it seems that camels may play a role in transmission, similar to the SARS virus where I think it was civet cats that were sold in markets were one of the vehicles. So, again, highlighting the way that diseases in animals may jump over and effect humans is something we need to keep vigilant to.

WILLIAM STRECK: Other comments or questions for Dr. Birkhead? Thank you. Thank you Gus.

GUS BIRKHEAD: Thanks

WILLIAM STRECK: We'll now move on to Dr. Boufford for her report on the Committee on Public Health.

JO BOUFFORD: Thank you. Let me begin by thanking Sylvia Pirani and the Commissioner especially for the hard work on the Prevention Agenda. We met, the Public Health Committee met on the 12th of September and as Gus said, we heard reports of the community engagement and that kind of activity going on statewide. The health improvement plans are due November 15, so that's our target deadline. The selection of problems among the

five continues to be dominantly in the communicable disease prevention area, chronic disease prevention, and in mental health and substance abuse which is very gratifying, because that was added really by the ad-hoc leadership group, and we're very appreciative the Commissioners of all of those agencies involved agreed to that.

There is technical assistance being provided statewide through regional agencies that have been funded by the Robert Wood Johnson Foundation to support activities and HANYS has also run three webinars on the prevention agenda focusing on the issue of partnerships, priority setting and picking interventions, and now on continuous quality improvement models for the interventions that are designed, and there have been 85 to 120 participants each time, each webinar, of those issues, and the Department of Health I think importantly has instructed all of it's categorical grantees to really connect to the Prevention Agenda activities in their local communities which potentially adds resources and intellectual firepower to those conversations in the areas that are synchronous with the selections of the local communities. Also, the DASH obesity prevention policy center has recently been commissioned by the Bureau of Chronic Disease to provide specialized technical assistance to those communities that have selected chronic disease prevention of their areas and there have been two webinars there. Each has had over 100 participants, which is

very, very gratifying – the level of interest. There are communication tools that have been developed. I'm going to pass these out for you. This is the sort of overall brochure that was created with support. Again, I just want to credit the Robert Wood Johnson Foundation and the communications department of – the department here for putting this together. There are also one pagers that accompany this for each of the potential stakeholders in the Prevention Agenda, so there's a page for hospitals, a page for business, a page for media, a page for academia with a sort of win-win, why you should be interested and get involved, and all of this, and as Gus said, we've been very gratified and again, the states been involved in these – very involved in these conversations in the responsiveness of the New York State Health Foundation on supporting local plans. So they have recently announced a $500,000 grant program which will be grants up to $50,000 with a matching requirement, but they can be smaller or as high as 50, will be available for communities who have approved plans in November to implement their plans. So this should be very, very helpful and the Foundation will also be convening other statewide foundations with the goal of identifying opportunities for local support of communities in the implementation process. So, that's very exciting.

The other exciting feature of the September 12 meeting was the presentation of the New York City Take Care New York agenda

cross walked with the State Prevention Agenda and discussions of the work they've been presenting in working with the Greater New York Hospital Association's leadership, so Deputy Commissioner Patsy Yang has been really instrumental in that presentation, and they've actually produced a document that shows the items that are synchronous between the Take Care New York, New York City agenda and the Prevention Agenda, and identify areas where this, the, because the City Health Department has obviously a lot of hospitals to relate to, where they can particularly, are seeking partnerships and can provide technical support. So, that's very gratifying as well.

I wanted to highlight a speech that the Commissioner gave at HANYS over the summer really emphasizing prevention as one of the keys to success in the overall healthcare reform, cost and quality agenda items as well as improving population health, and a recent letter to hospital directors urging them to invest in community service plans as part of their community benefit obligation, and so, and also indicating that the State will be requesting the community benefit plans from hospitals on an annual basis with all of the schedules filled out so they can see and how these investments are being made, and the hope being that as more and more people are insured some funds may be made available for investment in community-based prevention and broader determinants of health.

And finally the themes of the innovation grant really very strongly include the prevention agenda along with strengthening primary care and integrating behavioral health. So it's very gratifying, good stories, and we appreciate all the support, so thank you.

WILLIAM STRECK: Comments or questions for Dr. Boufford? I have one, Jo, and that's, on the substance abuse and emotion behavioral category, that very expansive category and the one Dr. Sullivan is soon to oversee, is there a tie into the new agenda that's being developed? The Office of Mental Health?

JO BOUFFORD: That's a good question. I mean the materials – I think part of that would depend probably on how well that information's getting disseminated to the community level at this point, because the prevention agenda goals, I assume to some degree reflect where that was going.

DR. SULLIVAN: Yeah, I think that it's very important that we increase that kind of connection across all these things that are happening so that we don't duplicate efforts and we kind of have a synergy of the efforts as we push it out. So I think obviously these are goals the office of mental health has as well. These are very important. But how we work to connect the dots and work together, I think, can probably be a little bit

improved over time. So I think I'll be working with Dr. Boufford and Commissioner Shah on how we integrate some of this into both agencies really working together. It's a huge agenda and it's so important. It's just so important. Thanks.

GUS BIRKHEAD: If I could make a comment –

WILLIAM STRECK: Certainly.

GUS BIRKHEAD: I think, yeah, it's a very good point and we did work with OMH and OASAS very closely in the development of the prevention agenda. Their staff actually let the Committee that, on the mental health and substance abuse issues, came up with those recommendations, so hopefully there's pretty close alignment there. I also now have met twice with the local mental health directors on this as recently as a couple of weeks ago and there's a lot of energy there as well. I think they comment that this has really opened up the doors at the local level with their public health counterparts and has led to win-win situations there for both elements at the local level. So hopefully we can keep this energy level going and I've committed to go back and meet with the local mental health directors again, and to keep very close touch with them, and in the same way with OASAS and OMH. So, really look forward to working with you on that as well.

WILLIAM STRECK: Thank you. Are there other questions or comments? OK. Thanks Jo. Dr. Rugge now will discuss the Committee on health planning activities.

JOHN RUGGE: Good morning. I think that everybody is well aware, our planning committee has been conducting a wide ranging set of discussions regarding the components of ambulatory care starting off with the various shapes of ambulatory surgery, high end imaging, and radiation therapy, and have moved on to the spectrum, the continuum of ambulatory care services on a hands-on basis reviewing the health department's proposal of the legislation last year of limited services or retail clinics. At our last meeting considering freestanding emergency departments including part time free standing emergency departments and also upgraded D&T centers which have in current regulation a place, although they've never come to exist but have a designation or category for a limited emergency services, i.e. urgent care. This wide ranging discussion as I see it is now about to narrow down. I think in the course of our discussions we've identified certain themes that keep recurring. One is that we value pluralism. We're not trying to find any one model of care that is best, but instead having a variety of models that work best for individual communities. That there is a need, however for clear labeling and

nomenclature and a set of services, and I think we're going to come up with five. That there is newly available ability to collect and analyze data and that has implications for reporting expectations in the future that up to now have not existed. And also been looking at the absolute need for bidirectional referral arrangements, so that referrals can happen across primary care or over to acute care settings on an assured basis without fail. And also a preference for accreditation by agencies, national agencies over direct state supervision in the form of surveys.

In order to pull these various themes and others together with Dr. Shah's help we've identified David Chokshi as a scholar and a fellow. He is a Gamble Scholar, a Truman Scholar, and a Rhodes Scholar – absolutely – and a Soros Fellow and a White House Fellow, and in a remarkable feat of speed and endurance on two weeks' notice prepared a seven page document which I think has been distributed to all council members which is, again, a remarkable exercise both in pulling together the threads of our conversation to date, setting a context for recommendation will be forthcoming, and also provided a vision statement that will be available I think not only for us now but will be useful in the future as we collect more data and we're looking at incremental steps providing a shaping experience for continuously evolving ambulatory modes of care.

To that end we are looking at a perhaps short committee meeting this afternoon to review and make suggestions regarding edits or additions to Dr. Chokshi's draft as our introduction. Preparing us for an all-day session, half-day session, tomorrow in which we will be considering urgent care, recognizing that urgent care is really the pivot between high end acute care in the emergency care setting and primary care in office-based settings or in clinic settings. Also realizing that just as in office-based care there are two modes. The entrepreneurial or proprietary mode with licensed physicians and not-for-profit institutional mode under article 28. So too in urgent care there's urgent care done by clinics and by health centers, but also urgent care being done on an increasing basis by private physicians. The open issues are what kind of commonalities? What kind of recognition? What kind of common traits should be identified and then what kind of naming convention might be in order, as well as what kind of accreditation.

With that discussion we will then move into our special meeting in November, at which time I would expect we would have a draft report with a series of recommendations for initial consideration by the Committee at that meeting leading to presentation on schedule in December for the full council to review.

Along the way we have enjoyed amazing support from the health department. There are identified subject experts on each

of our topics. We have had option papers which have been very well developed, in fact, so well developed it can be hard to absorb because there's so much information regarding what's being done in Oklahoma versus Arkansas versus Massachusetts and so many options for us to narrow down. Again, one more reason why I think the new introductory essay will be helpful to us as we try to get our arms around a very big series of topics. In addition, the Department has been working very hard to engage the legislature so there'll be some understanding and receptivity of the recommendations we are making, and this was made manifest by Assemblyman Gottfried attending and really participating as an honorary member of our committee in September with I think some very helpful advice for us, and a continuing interest as we share with him the papers that we're receiving, and we're looking for a similar outreach on the Senate side so we have bicameral engagement and involvement. So, we expect to have an interesting afternoon and an interesting day tomorrow and a productive set of recommendations for us at our next meeting.

WILLIAM STRECK: Questions or comments for Dr. Rugge? I think the key phrase was your comment that you're having a perhaps short meeting this afternoon. So, I'm sure that caught your committee members attention. No further comments, then we can now continue on and we'll move on to Mr. Kraut. First with

the report— OK, I will just turn it over to you and you may change the order as you wish.

JEFF KRAUT: So, just before we begin I think I'm going to ask Mr. Abel to talk a little – give us a little update on the activities and the discussions we've had on some CON streamlining activities.

CHARLIE ABEL: Thank you. Just a few minutes to very quickly go over the status of the PHHPC recommendations for CON reform phase one and phase two. As you know, Phase one recommendations were submitted to the Department in June of last year, so what we have accomplished; the Department has streamlined a review process for integrated behavioral health and physical health services. We've worked with the other agencies, our sister agencies, and we have in place a streamlined process for that. We have expanded our acceptance of architecture and engineering self-certifications. We have finalized MOU and a process for DASNY review of architectural drawings to help expand the resources that we have available for CON reviews. Oh, by the way, there are now architect and engineering certification forms now uploaded on the web, uploaded within the last week or so, so applicants please be advised to use the new forms. We have enacted the requested revisions to our limited life policy, basing the limited life on

an operating certificate expiration date and not on limited life of the establishment approval, thus facilitating the reviews of limited life extensions. We have committed to a continuation of the NYSECON development as evidenced by a 2013-2014 contract for continued development. Things that still need — and we have for the remaining phase one recommendations which required legislative or regulation changes, we have drafted all new regulations. We had included proposed legislation within the 2013-2014 budget bill. Unfortunately the language associated with the implementation of those recommendations that required new statute, that language was omitted from the enacted article 7 bill. So we are working to reintroduce those pieces of legislation to further implement the phase one recommendations.

On phase two, 23 recommendations in all. Phase one had nine. We have implemented a – well, we have accepted the recommendations for retaining CON for hospital beds for the next three to five years. We have implemented a process for ACO certification in lieu of CON. We have regulations drafted. We have – we are well underway in updating the hospice need methodology. We've had a workgroup established. We've been soliciting industry input. You can expect to hear more about that over the next few months. We have updated a DOH, the DOH process for approved pipeline projects reviewing all projects that have contingent approval but have not progressed, and we've been moving forward with applicants being contacted. All

applicants have now been contacted, but all applications that are over five years old and have had contingent approval, and we're doing that, we've implemented a process for an ongoing review of those types of applications. Either the applicant needs to demonstrate that the project is still viable or we're proceeding with abandonments. We have implemented the – one piece of statute that we did get passed in the budget is the temporary operator statute to, and strengthen the DOH authority to respond to failures in governance. We have also internally implemented new financial and quality dashboards so that we can – when we meet with facilities to discuss their projects or they happen to be struggling facilities looking for some assistance in some form or fashion, we have been presenting these dashboards to individual facilities and for their information and review. At some point we expect to move forward with a public internal report card like that, but we have some ways to go in that regard. But we are using that for internal decision making.

We have come up with a ranking of hospitals and nursing homes in the State with respect to financial strength and quality metrics. We have relaxed our prohibition on revenue sharing with revised policy on the interpretation of 600.9C. We have draft revision to that regulation circulating within the Department and expect to be able to move forward with promulgation of that regulation at an upcoming meeting. And we

have obviously moved forward with the PHHPC recommendation for reviewing construction standards, in the wake of environmental problems like tropical – well, hurricane Sandy. We of course, had the ad-hoc committee come through PHHPC and we've revised our regulations and they are in draft form. Again, many of, several of these phase two recommendations do require statute and again, they were all the recommendations that include a statute were included in the original, the Governor's budget bill and all except for the temporary operator was omitted. So we're in the process of moving forward with reintroducing those pieces of legislation.

Of note, with respect while the recommended changes to the character and competence review process, the matter of standardization of process and what constitutes a taint. If you'll recall the recommendation was to go add some flexibility to the interpretation of taint and move from a 10 year look-back to a 7 year look-back while that requires statute for article 28 providers it does not require statutory change for article 36 and article 40 providers. We've used the article 28 standard by policy for article 36 and article 40 providers and as now that we have accepted and embraced that the 7 year look-back with greater flexibility is going to be our standard, we are implementing a revised policy for the article 36, article 40 providers to implement the recommendations at this time, with 7 year look-back, flexibility on the taint rule.

One element that I did miss and it's a phase one implementation is a reduction of the number of outpatient services as we consolidate our licensure standards. We have come up with a new list of outpatient certified services. It is dramatically reduced, and the expectation is to implement by the end of 2013 as we need health facility information system changes in order to be able to implement and we expect those changes to be made by the end of the year. I know that is very fast but I'd be happy – and we expect to be able to do some periodic updates as we go along and give you something with more substance as well. But if there are any questions, I'll take them.

JEFF KRAUT: Are there any questions for Mr. Abel? You know, when we do the annual meeting, the February meeting, we'll have a list of how many applications we're given in process, so we'll have a sense to see if some of these regs have decreased the volume or increased the volume – you know the talk concept of unintended consequences, but I have a sense it might have decreased the volume. And hopefully you'll also tell us the timing and processing at that time, would be helpful.

CHARLIE ABEL: Yeah, I can give you a little year-to-date information if you'd like. And I mentioned this at a – I think it was a HANYS discussion we had. Last year 2014 – 2012 was

almost $4 billion in capital, and the largest capital, gross capital in approved projects of any year. And the number of applications that we've reviewed has actually gone up. To date we have approved in 2013 $2 billion in capital with another $2.4 billion under review. There doesn't seem to be any letup in applications relative to capital improvements of the facilities. We have last year, as we reported at the February 2013 meeting we made a—the Department had a 34 percent improvement in it's review time across all review, all types of application review. 34 percent, 2012 better than 2011, and year-to-date 2013 as compared to 2012 we had added another 28 percent improvement to our review time.

JEFF KRAUT: all right, well, that's great, and we're going to – this is what we wanted to do when we started this process, and hopefully we'll continue to chip away at this until we get to some (diminimus)[sic] numbers that require to go through CON and hopefully we'll eliminate that for as much as is practical. Thank you. I'm going to – one of the things Mr. Abel mentioned is they proposed regulations to amend the health code with respect to the recommendations of the ad-hoc advisory committee, and so it's a little out of order, but now we'd like to present those recommendations so they can enact code changes. And you'll recall back in May of 2013 a moratorium was issued for those facilities contemplating construction, major

renovation located in flood plains to give us an opportunity to examine the code and made recommendations consistent with our new knowledge based on those severe weather events of Sandy and the previous Irene and upstate flooding, and also recognize new knowledge that's been incorporated to mitigate the impact of severe weather events and make facilities more resilient. So what we had done is we looked at — we formed an ad-hoc committee of the Establishment and Project Review. We began our work in June and I just, what you have in front of you is a report of that committee's work that made recommendations to the Establishment and Project Review committee in September. I just want to, before I turn it over to Mr. Schmidt for a brief kind of summary overview of the report, because many of you had been present at the Establishment Committee, so we'll not go as lengthy as we necessarily did, but I want to recognize his work and that of the Department, of Lisa and Colleen and all the staff who assisted us in – Mr. Deering's office who is Tom King who assisted us who assisted us in getting the work done, and we were joined by several members of the Committee. You'll see their names on the inside cover of the report, but I want to make particular note and thank those people who were very generous of their time. The Mayor's office had done in parallel another initiative on rebuilding and resiliency and there was a subcommittee that looked at those efforts in healthcare that was headed up by Ophelia Roman and Maurice LaBonne. They provided

us with invaluable information. Their report was integrated into it, as well as Mr. Primeau and Mr. Nichols who works for the State helping us with code and the concept of the evacuation zones. And the generous time that was given the Committee by representatives by Memorial Sloan Kettering, the NYU Langone Medical Center, both of whom are contemplating part of those billions of dollars of capital we approved up on the upper, East Side, proximate to the water, and Wayne Mettier from Our Lady of Lourdes Hospital in Binghamton who had experienced, what can I say, probably three, 500 or 100-year floods in a span of six to eight years, and how they mitigated and got through the last flood, and you'll see a picture of essentially creating a bathtub around the hospital. That's the picture on the extreme left of the cover. So we just got a wonderful support from the New York Chapter of the American Institute for Architects, the Urban Green Taskforce that was developed by the City Council, and I can go on and on. It was a wonderful communal effort I believe, including representatives from Greater New York and HANYS as I said before. So that permitted us to have a task, to have a charge and do our work in what I would say is a very compressed time frame, and you see the efforts of that. So as that as an introduction, I'll turn it over to Mr. Schmidt. There are eight critical recommendations that were done, and I just would ask you Bob, to kind of do the top line stuff. And then I'm going to ask for the Committee to accept this vote, to

accept the application – to accept the report and the recommendations so the Department could modify that code in consistent with these recommendations. Bob.

BOB SCHMIDT: Thanks Jeff. I'll go through these recommendations quickly. We had a PowerPoint on a more detailed overview of each recommendation for the Establishment Committee, so, they're in section three of the report. I'll start with recommendation number one. The Proposal is to amend title 10, section 11.3 site requirements. We want to move everyone from constructing to the 100-year flood crest level to 500-year. And that'll be for new construction and facilities that are undergoing a major renovation.

Recommendation two is to add a few additional items into the hospital code; things that were uncovered as critical features as a result of Sandy. One would be having external hook-ups to your power system, external hook-ups for your HVAC boilers and chillers, few items like that.

Recommendation three is that these new standards would apply to all facilities, not just hospitals or nursing homes. Anything that would be certified under article 28 of the code.

Recommendation four is, addresses access to patient health information so that when evacuation or transportation of patients to other facilities takes place, there's ready access to medical information. Recommendation five is forwarding the

voluntary adoption of these standards for existing facilities. So we didn't want to make it – little more detail on that. You can read that in the report.

Recommendation six is a recommendation to lift the current moratorium that exists on construction and renovation in flood zones.

Recommendation seven deals with regional planning to make sure that the physical plant portion of the hospital nursing homes plan is integrated with emergency services. More detail on that in the report. And then recommendation is setting up mechanisms so that PHHPC and the Department can oversee mitigation activities over time. So we can keep track of which hospitals and nursing homes, other facilities are becoming complied with these new standards and who's best to handle situations when the need arises.

Recommendation eight, I don't know if you have any questions. That's a pretty quick overview.

JEFF KRAUT: That was great. And so theo – there's a lot of nuances and background to almost all the arguments in the report. we tried to explain it. But if anybody has questions or any thoughts we'd certainly like to hear now.

WILLIAM STRECK: Jeff, just on the process, so this is the substrate for the codes that will subsequently be developed and go through our regular code process?

JEFF KRAUT: I would just tell you that our code with respect to facilities in flood plains, there is literally one reference. Anybody in a flood plain has to build to the 100-year crest level, and what we're basically saying, you move it up to the 500 year level. Now, depending on where you are in the State, that's a difference of between one and two feet. But it makes all the difference, and then we're requiring emergency connections, things that we're not requiring now so that if your facility fails or there's a critical access, a critical infrastructure thing, that you build preconnections so you can come right in there and connect up. It's like, I'm not going to say it's plug-n-play, those are the engineers would be offended by the simplicity of that statement, but it certainly will decrease the time that you're potentially down by having these built-in things. And as Bob made reference to, for existing – this is for facilities in newly constructed or major renovation which is defined in the code, so for existing facilities, the City Council may be undertaking codes in New York City to require everybody to come up to these standards over time recognizing we were dealing with the entire state, a lot of long term care facilities where there's an economic consequence of

this. We felt we'd sooner start with voluntary adoption of those standards. And we suspect that anybody who's investing the type of money we have to in contemporary healthcare facilities are going to make those investments anyway as they go through the facility just to – if there's a risk of that they'll certainly take it into account.

If there are no – go ahead.

ANGEL GUTIERREZ: Just out of curiosity, I don't remember dealing with this in the previous report, but in 1513 who was here to measure how high the flood would go and how is a 500-year limit determined?

JEFF KRAUT: Bob, do you want to reference the 500 – the 500 is actually a statistical – it's in the report. I can't do this from memory because I will get it wrong, but to better understand the difference between 100 year flood and a 500 year flood, it's referred to them in statistical terms. They actually are measures of probability. The 100 year flood has a one percent chance of happening during a single calendar year, or insurance terms, a facility has a 26 chance of flooding during the life of a 30 year mortgage. In contrast, a facility located in a 500-year flood zone carries substantially less risk with a 0.2 percent chance of flooding in a single calendar year, and there's a 6 percent chance of occurring once during the life

of a 30-year. So it's the probability of a flood occurring is twice, I think I'm getting the math – it's almost twice – five times more likely. I was absent for a lot of fourth grade math. But it's the difference in level is a five time – is a five-time greater probability that the flood will not affect your facility. And it does vary where you're located, and FEMA constructs maps which are frankly being updated now, and digitized so that information is more available and contemporary engineering standards I think are particularly in healthcare are pushing everybody to that higher comfort level wherever you are, because today you may be in a flood zone – you may not be in a flood zone, but as we found, you were in a flood zone now based on what just happened.

I would like to make a motion to the full council to adopt – to accept the report of the ad-hoc advisory committee on environmental and construction standards and to adopt the recommendations therein, and for the Department to take any action to effectuate the implementation of those recommendations.

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

Aye.

Opposed? Thank you. The motion carries.

JEFF KRAUT: Thank you very much. And again, Mr. Schmidt and all the staff, we really appreciate the effort you put into doing that.

ROBERT SCHMIDT: Thanks, Jeff.

WILLIAM STRECK: Dr. Martin

GLENN MARTIN: Yeah, no, I know it’s our council; apparently our habit is to thank people after they’ve left. But actually having served on the Committee I do want to thank our mathematically challenged chair for doing a marvelous job. We got a huge amount of work done, and also to thank obviously, the staff from DOH. We got a huge amount of work done in a short period of time and it really should be commended.

JEFF KRAUT: Thank you. I’ll be in Vegas next week playing the big room. We’ll go on –

ROBERT SCHMIDT: Actually, Jeff, can I have one more thank you? I have to thank Tom King from DLA. He’s actually

leaving the Department and moving on to a different job after his committee work with us.

[laughter]

JEFF KRAUT: Is that coincidental? Or unrelated? All right. Thank you Tom. OK, now I'd like to present the meeting of the September 12 meeting of the Establishment and Project Review. For the Certificate of Need applications. We have about 37 or 40 applications to go through, and we're grouping them in accordance with our policy. So first I'm calling category one applications for construction. This is application 131304C, Peconic Landing at South Hold in Suffolk County. To certify an additional 16 residential healthcare facility beds to an established continuing care retirement community. Both OHSM and the Committee recommended approval with conditions and contingencies, and I so move.

Second.

WILLIAM STRECK: There's a motion and a second. Is there further discussion? Hearing none, those in favor, Aye.

Aye.

Opposed? Thank you. The motion carries.

JEFF KRAUT: Now I'm going to move category two applications. I am going to exclude one of these from the applica – from the grouping which, so we could take it up separately based on some of the communication we received. The first is application 131186C, HCR Clinton County. An interest declared by Mr. Booth and Ms. Hines. Application 131187C, HCR – I'm sorry. I'm not calling that application.
The 131186C, HCR Clinton County is to expand the CHHA services to include Essex, Hamilton, Franklin, Warren, and St. Lawrence Counties.
Application 131188C, HCR Schoharie County. To expand the certified home health agency to include Otsego County. Mr. Booth and Ms. Hines are declaring an interest.
Application 121267C, TLC Health Network, Lakeshore Hospital in Chautauqua County. An interest declared by Mr. Booth.
That's going to expand the long term home healthcare program by establishing a CHHA to serve – Cattaraugus, Chautauqua, and Erie County. OHSM recommends approval with condition or contingencies as does the Committee, and I so move.
Second.

WILLIAM STRECK: There is a motion and a second. Is there discussion on any of the applications as presented? Dr. Berliner.

HOWARD BERLINER: Jeff, I'm not sure why you excluded one of these from the batch and not all –

JEFF KRAUT: I excluded Madison County because there had been a recusal declared on that, and so the recusal I have to take separately.

WILLIAM STRECK: Ms. Hines.

JEFF KRAUT: So, obviously the comment that you started the meeting with was related I think, to these applications. There was a debate that began in writing amongst interested parties after the establishment committee made it's recommendation. I would actually like to suggest that we consider sending this back to Establishment, because that's the most appropriate place for the debate to occur. It shouldn't occur in writing in between. And while we would typically expect anyone interested to know when an application is up for debate and be present to have that debate at Establishment, I too fell into the category of being unaware that because of the structure of the application that each of the individual applications by HCR had multiple counties attached to it. So I am swayed by some of the letters from interested parties about the fact that they were not aware. I think it's unprecedented and the State can correct me if I'm wrong, that a single

applicant in the CHHA CON process has had more than one application in, on a single agenda. So the fact that they were three separate ones, I until I read the applications on the way down, I also thought that they were for individual counties, and not inclusive.

WILLIAM STRECK: You're free to respond. I think that she's arguing the –

JEFF KRAUT: You want the whole batch excluded?–

MS. HINES: No, I just want – I'm just suggesting that the two HCR applications go back to –

JEFF KRAUT: There are three HCR.

MS. HINES: But you didn't include the

JEFF KRAUT: I only excluded one from this vote. So I only excluded one from the vote. You said you want two to be excluded?

MS. HINES: Well, then maybe I'm missing – so the –

JEFF KRAUT: But there's three HCRs. That's all I'm making a point to you.

MS. HINES: Right. So I'm suggesting that all three – yes.

WILLIAM STRECK: You are.

MS. HINES: Yes, I am.

WILLIAM STRECK: I think that's what you are suggesting. Yes. Is there further comment on this question about which there has been much correspondence? Mr. Fensterman?

HOWARD FENSTERMAN: I think we have a precedent for this, and I think Ms. Hines who is a member of the Establishment committee, if she is indicating that she did not have the proper information in front of here when rendering her determination, or the facts in front of here, I think that perhaps it should go back and I support her position on it.

MS. HINES: If I may, I'm not – I appreciate the support. I'm not actually saying that I did not have the facts in front of me. What I'm saying is that until I did my full prep for the Establishment committee, I assumed that each of the

three applications were solely for the individual counties that were listed on the agenda. So I am swayed by some of the letters from potential opponents of the application that they were also not aware and so missed their opportunity to discuss it. So I just think from a process perspective, we ought to provide that opportunity. That's all I'm saying.

WILLIAM STRECK: Mr. Fensterman.

HOWARD FENSTERMAN: Yeah, I just want to make an additional comment, because this is consistent, Mr. Chairman, with what you said at the beginning of the meeting. There's a distinction, I've said this before at Establishment and I believe here as well. The issue for me besides supporting Ms. Hines position is whether or not an applicant, whether objectants were fully aware of their opportunity to appear. One of the things that has always disturbed me is if someone who did not appear puts in a letter to us after the fact, I believe that they have thereupon waived their ability, because we give them an opportunity to come to the Establishment committee and address that committee as to any questions or issues they may have. One of the things that the letters that were sent became really apparent to me is there was at least a statement that they weren't clear from the agenda what was on the agenda. And that's something that is of concern to me because I want to make sure that everybody – if we

weren't absolutely clear, then that gives rise to a concern to me.

WILLIAM STRECK: And just to reiterate, the questions that have been communicated to the Council have been that the agenda listed as does our agenda today, specific counties as an agenda item in the background material as Mr. Abel would point out, the specifics of those applications were well-delineated. But I think Ms. Hines point is that if you went to the agenda to decide whether you were going to read the fine points, you might not have felt that you were motivated to do so based on the agenda. If that – may define that as the question before the Council at the moment. Mr. Kraut.

JEFF KRAUT: We should've had the discussion before I called the meeting. So, I understand the point. I think there is a – if you look back on the history of this, we've, it's been very heated, it's been ostensibly competitive and then not competitive and then everybody has weighed in. With respect to how we do the agenda, the agenda is just that; it's an agenda. It's to inform you there is an applicant there. The process is, the county that's located is the county you enter into the NYSECON process. It is the county of where the applicant is making application from. It is not relative to the service area. It has never been relative to the service area. If you

look back in our July agenda, if you look back in our May, in the previous years' agendas, we have not departed from that process. It is the county where the NYSECON, you type in what county you're making the application from. It is the obligation of the healthcare industry to read what we write. It is the application to pull up the – I believe this very strongly – we have tried so hard to make this information transparent. We have really worked at getting it out there in a timely basis. You have to have – there's an obligation here of objectants to be informed, to have somebody looking at this, there's a reason why we put all of our actions up on the web so you can view it, and I'm sorry – you know, I feel differently. If an objectant didn't take the time to say, oh, there's the agenda, there's a home care I may or may not know, you've got to flip open and open up the link to the attachment. You have to read at least the green sheet, and the green sheet is absolutely specific in each application what the market's going to be. So, you know, I understand, I'm sorry, but I can't reward laziness at one level or just poor management at some extreme level that this is a manager's responsibility to know what's happening in the field. And we certainly publish the fact that these are coming on. I feel, unless there was a procedural error which I will grant that we violated something here, and I looked at the record. We gave every opportunity for the public to speak. That's how I feel.

WILLIAM STRECK: Dr. Berliner.

HOWARD BERLINER: This is a rare occurrence but I have to disagree with my colleague, Mr. Kraut. I mean, this is not about us. We have a responsibility, if you will, almost a fiduciary responsibility to read the applications in full, and know what we're voting on. We certainly assume that large institutions have the staff and capacity to go through all of this stuff. But we can't make that assumption and in the past we've been burned by making the assumption that the public, whether those consist of other kinds of healthcare entities that may not have the kind of staff to do that will go through the entire book. I, you know, we may know that what's listed on the title is the county, is the county of origin, not necessarily the service area. I'd be willing to bet that the vast majority of other people even in the health industry in the State are not aware of that. And I think this is just a case where, not saying whether the application would be approved just because someone wanted to, or not approved just because someone had something to say about it, but I think our responsibility to some extent is to the public and I think the way that this worked out seems to not have been fair to the public.

WILLIAM STRECK: Dr. Brown.

LAWRENCE BROWN: As a rookie, it is particularly instructional to me to receive all the communications that we have and to learn more about the responsibility of the Council and the Committee. I must confess that I have (lenience) in both directions arguments. Because I think one can make a cogent argument how the public is best served. Whether best served by doing a review as has been suggested by my colleague or review suggested by Mr. Kraut in terms of not doing the review as suggested by Mr. Kraut. I guess I have one question if I can ask, and I'm not sure who would be able to answer this; do we have any information about the impact of us postponing this to the public? I would like to get a sense about that if we do have such information?

WILLIAM STRECK: For that answer, we'll turn to Albany. Becky are you there to address this?

[you're still on mute, Becky]

WILLIAM STRECK: There you go. Now we hear you.

BECKY FULLER-GRAY: OK. Sorry for my non-technical side. The question was the impact on the process to date. We have been working now for 18 months making recommendations to the Public Health and Health Planning Council, reviewing applications based on established criteria in an effort to work

with the Office of Health Insurance Programs to implement the Medicaid Redesign initiatives that were in part responsible for this initiative back in December of 2011. We have been working to make sure that the approved providers have their policies and procedures in place, that they're opening and expanding as quickly as possible so that the Medicaid Redesign initiatives for home and community-based services can be implemented statewide. The approval of CHHAs in counties that we're making recommendations to. It's important that that provider network is established and in place. The impact would be a delay in making the recommendation to the Public Health and Health Planning Council to move forward with this recommendation.

WILLIAM STRECK: Thank you. So, Mr. Levin.

ART LEVIN: I'm just wondering, this doesn't address the entire question of whether there's a good reason maybe to legend the agenda with a caution that if people have any interest, this is all the information, if they have any interest they must go to the link on the whole application sort of as a warning.

WILLIAM STRECK: Well, that's a futuristic approach, which has merit perhaps. Are there – Dr. Shah.

NIRAV SHAH: I just want to suggest that this is you know, obviously an important issue to many people and we have considered it. It think the precedent that we set by continuing to respond to improper channels of communication that have clearly been publicly stated to be improper. There are timelines, there are deadlines for a reason so that the public can be made aware, and if we yet again break with – and essentially set a precedent that we are open to such communication, where do we draw the line? Obviously it's very important, but there was not procedural error made. Transparency, every effort was made at transparency in this case. This is again, about Medicaid Redesign, about trying to advance the goals of what the Governor's major initiative is to the extent that savings and costs and other things are additionally implicated as a result of our choices today. I think that we should try to stick to what we know and what we do well as bounded by good practices as we know they are.

WILLIAM STRECK: Ms. Hines.

MS. HINES: So I am loathed to disagree with you. I apologize. I don't believe there was a procedural error at all. I believe that we have again an unintended consequence of a uniqueness to the agenda. So, I'll go back and say, and I'm purely talking about procedure. I'm not talking about the

debate itself. I'm talking about the process. The agenda, the way the agenda was structured, it was correct, but it was different than any other prior CHHA RFA agenda item in that a single organization had three different applications, and so as I said, it was not even clear to me who knows this inside and out until I read the full application. So I would just go back and say there was a uniqueness to this that I think from a – it was unintended but it did not allow for full transparency.

WILLIAM STRECK: Other com – Mr. Fassler.

MICHAEL FASSLER: Just a point to clarify. We had a bunch of New York City applications, multi county. Were they listed only in the home county? So again, same thing. People knew. You had to look at the whole application.

WILLIAM STRECK: Dr. Martin.

GLENN MARTIN: So I guess this is just a point of information. It's a little bit of what Mr. Levin had pointed out. It seems to me that for certain applications, if I was following the process properly for the last year or so, DOH takes an affirmative action to actually check if anyone has a problem. So if we're opening up an ambulatory surgery center, we actually go out to the hospitals in the area? Is that my

understanding? And ask them if they have any opinion about this? Because we actually assert, I believe we go out and check to see if they have a problem and we notify them. So if that's the case, would just be a situation where we don't seem to have a completely level playing field throughout the whole process. Again, I don't think we did anything wrong. I'm leary about reopening this because people didn't follow the rules as they existed, but I kind of think that it might be worth looking at the rules that we're playing under if in some cases we go out of our way to find out if there are objections, concerns, or unintended consequences, and in others it's a buyer beware. You've got to go through these 400 pages and figure it out for yourself.

WILLIAM STRECK: Other comments? Dr. Gutierrez.

ANGEL GUTIERREZ: Procedurally I'm not sure. Are we discussing a motion? I don't remember hearing a motion?

WILLIAM STRECK: No, we have a motion. We have a motion. It's a complex motion because there is an unintended applicant in this debate.

ANGEL GUTIERREZ: I'm going to amend the motion as soon as we have a chance to.

WILLIAM STRECK: Yes, we do have a motion, and the motion was to approve two of the three and the TLC. But we will straighten out our motions if we can straighten out our discussion. Other comments?

CHRIS DELKER: Dr. Streck, this is Chris Delker. To Dr. Martin's comment about how we make an active effort to contact hospitals in the case of a proposed ambulatory surgery center, that's not so much to actively inform the hospitals. The reason that process came about over 10 years ago was that the hospitals were commenting even without our advising of applications, and the problem was we were not getting uniform information. So we send out a letter with seven specific questions to ensure that the hospitals address relevant factors in measureable quantitative terms. You know, the specific dollar potential dollar loss they foresee, whether or not any of the application physicians practice at the hospital, what their current OR capacity is. So that's done so that the Council really has – it's done so there's some consistency and some discipline frankly, in what the hospitals submit rather than some generalized statement against ASCs. So, you know, that I think is the reason that we do that. It's not so much to make sure the hospitals know about it, but to make sure that what they send us is understandable.

WILLIAM STRECK: Thank you. Dr. Martin.

GLENN MARTIN: No, I appreciate that and I know it came out of a good reason and apparently it works well. But in unintended consequences you give people notice and they have an opportunity to respond. Frankly if we had gotten – it's quite possible the other CHHAs have been given notice that somebody wants to open up in your back yard they'll be the fourth one in this county, do you think this is going to have a bad consequence in terms of your financial viability, yada, yada, yada… they would've been happy to respond directly. We don't do that in this case. I'm not saying one way or the other, but I just point out there it's inconsistent on how we, how various people in a region that would be affected by an application are treated in this process and this would appear to be an unintended, or maybe intended consequence. That's all my point is.

DR. SULLIVAN: Clarify I think what Mr. Fassler said. So there have been, I know there were in New York City, but there have been other applications that have come in this way where there have been multiple expansions and only the one county is listed. And that's somewhat known, I'm assuming, if that's the

way it's been all these years that people know that. So that has happened. It's not the only unique application. OK.

JEFF KRAUT: So, address that question.

BECKY GRAY: Yes, I can address that. Yes, it has happened and in particular with the downstate/upstate splits that we presented to you, applicants had submitted more than one CON; one for downstate, and one for upstate to capture their RFA approval. So this is not the first time that we've seen multiple CON applications from one RFA applicant. Probably for upstate it's maybe the first time, but for the downstate/upstate split there were several.

WILLIAM STRECK: Mr. Kraut, why don't we conclude this part of… at this point. Dr. Sullivan's point.

JEFF KRAUT: Your point about the county splitting stuff; so a couple of things. First of all very few CONs with the exception of home care, long term home health and hospice have county-specific designated service areas. I may be missing some, dialysis or something else, but very unique. So you were not only approving the provider – please don't make us leave – so you're not only providing the county –

[building fire alarm test]

WILLIAM STRECK: I want to congratulate the Council for handling this testing so well. Jeff.

JEFF KRAUT: And here's an example of redundancy being a virtue. So you have an applicant that submitted an expansion into 10 counties, and Ms. Hines is correct. Normally there would be a single application. They would say, we're expanding into 10 counties, and everybody would take a look at it and the home county would've been wherever the home county is. The applicant claimed that the Department asked them to break this request into four new applications, so that's what caused, I think, the ideology of this is first it's an RFP; it's not a normal process. Two, an action was taken to put these into four pieces around four regions of the State, so I think the need and the methodology could be evaluated instead of this big swath of the State in more local and smaller areas and they could look at need, they could look at volume, they could look at the impact. So, an unintended con – this is the correct way to do it from a perspective of planning, and trying to understand the impact in a region, and what we're now saying is that action has led to a misunderstanding that it's, it wasn't a fact these regional applications. Now, again, given – well, I'm not going to repeat the comment. But I'm concerned about the precedent and the

precedent being so we take an action; somebody could come in and say I didn't know. I didn't know the am-surg application was going in and I'm an existing am-surg center. I wanted to oppose it. I didn't know – something else. That's the precedent. As narrow as you close that precedent, somebody's going to barrel through this and it's going to be problematic. I believe it will be.

WILLIAM STRECK: Dr. Gutierrez

ANGEL GUTIERREZ: I'm still stuck in procedure here. My memory is – an item or exhibit six in page three. We approved number one, flip the page number three and number four.

WILLIAM STRECK: No. We approved item number one. We have before us items one, three, and four. Those are the ones that were proposed under category two – two was excluded. And we have to clean that part up in terms of advancing this.

ANGEL GUTIERREZ: So, we are voting on that?

WILLIAM STRECK: We're not voting.

ANGEL GUTIERREZ: Whenever. OK.

WILLIAM STRECK: We have to work through that little procedure too. Mr. Fensterman.

HOWARD FENSTERMAN: There are a lot of very meritorious arguments made on both sides, and the precedent issues are a concern of mine as well. My questions, perhaps this is for Colleen. We've been told now that we have had this happen in the past. Were the agendas structured in the same manner in the past?

OK. Mr. Chairman, my comment is then that we, you know, we go back to other discussions we've had with CHHAs which you have articulated which is trying to treat everybody who's coming later in the same was we treated people that came before us. And that becomes, that's a precedent issue. So I think Mr. Levin's comment is obviously there is a recognized issue. I agree with my establishment chairman that the folks are charged with the responsibility, but it appears that maybe they don't know that they're charged with that responsibility. So, perhaps in the future we can look at make them aware somehow by sending out some sort of missive that you are charged with this responsibility because our agenda's going to be structured and set forth the same way we have been doing it. Thank you.

WILLIAM STRECK: I have a question for the Commissioner, if I may. The communications that were received by the Council

expressing concerns about the misinterpretation of the agenda, it was not my impression that all of those were inappropriate or untimely – OK. So, I just want to clarify for the group. Because that's a part of the process too. That people can write us and express concerns and engender discussion at this council. So there were some later communications that would not be deemed appropriate. But I would – I just want to clarify, I want to characterize all the communications expressing concern about this for the reasons that have been expressed, whatever your position on those reasons were not inappropriate. People may communicate through the office to this council about the actions of the Project Review Committee or other committees prior to the Council's deliberations. And we may consider that information as long as it comes in under the protocols we established.

NIRAV SHAH: Yes, as Colleen said, and she didn't have a mic, this kind of an agenda has been sent out in the past for prior applications with the same level of detail for the same kind of approvals. This is not a unique case. What is unique about this is that the last two communications that we received as council members directly fell outside the usual and approved and accepted means of communication to the Council. We are certainly open to communications to the Council directly through Colleen up to a certain date. We will clarify that again for

the public on what the right means of communication are, and I think that basically sets the ground.

WILLIAM STRECK: Thank you. Is there further discussion on this? Ms. Hines.

MS. HINES: So your distinction I think is an important one, and so it would be helpful to know which of the documents are appropriate for discussion here versus which are not. I imagine the first one that was received by an opponent from VNA homecare that sort of started this bevy, I think, of debate by mail, may count as something that's debatable? Is that correct?

JEFF KRAUT: [This one was never forwarded because you got it 5:00. This was a rebuttal to the rebuttal.]

WILLIAM STRECK: The series of exchanges and rebuttals have been disallowed by the court, but the initial letter from VNA would have qualified. Right? Yes. So the initial letter objecting to – touching upon the core question you have raised and we are discussing in terms of understanding what was being dealt with.

MS. HINES: OK.

WILLIAM STRECK: So that I think we're OK to discuss it based on that letter. Dr. Shah is right. The latter discussions would not be part of our considering.

MS. HINES: OK. Fair enough. So the only other comment I would make and it's one of the reasons I have a strong belief we should send it back to establishment is because that letter in addition to my argument that I think we had a different and unprecedented approach, simply because we had split this into regions and that has not happened before and the public was not aware that that had happened unless you had gone in and read all the application materials. That first letter made some allegations that I think deserve discussion, and I don't know that this is the right place to discuss them.

WILLIAM STRECK: Mr. Hurlbut. Thank you.

ROBERT HURLBUT: Thank you. Just for my own clarification, with the project numbers that we're talking about, Mr. Kraut are we talking about project number 131186C? Is this part of this debate?

JEFF KRAUT: Yeah, I called 11–86C in Clinton County, HCR Schoharie, and I called 267 TLC Health Network. I excluded the

Madison County one which was the subject of all the correspondence because we have a recusal listed on that.

ROBERT HURLBUT: So, where does project number 186C sit?

JEFF KRAUT: That's before you right now.

ROBERT HURLBUT: Is that the one we're talking about where it's the problem? Or not?

JEFF KRAUT: That's not the – there's been – to my knowledge there's been no objection to that application.

ROBERT HURLBUT: Because I just want to point out that the request—

JEFF KRAUT: Only Madison.

ROBERT HURLBUT: the request to expand is in Essex, Hamilton, Franklin, Warren, and St. Lawrence Counties. So, in other words, my point is, she followed – the applicant followed the process. And we're not having any issue about this. So why are we having an issue about the other.

JEFF KRAUT: Ms. Hines—

MS. HINES: I'm not quite sure I understood the question, but I have to say – so, again, in terms of clarity, so perhaps the arguments that I'm making only apply to Madison County. I'm not sure which counties are in which of these applications related to the opposition. And I hear you say it's only Madison County. Is that correct?

JEFF KRAUT: You can correct me, the only letters we've gotten was for the application I did not call.

MS. HINES: OK. So then I will simply transfer all of my comments to that application.

JEFF KRAUT: All right.

HOWARD BERLINER: Does that include the letters that have not been forwarded because they came in too late?

JEFF KRAUT: The letter that came in too late which was 5:45 last night is a rebuttal to the rebuttal letter about Madison County. 4:55. Excuse me.

WILLIAM STRECK: So are there – Dr. Sullivan.

DR. SULLIVAN: So, it's my understanding that the letter that can be discussed is the VNA letter. So my only question to clarify just because of procedure is if you, that one comment somehow about – it's in the second paragraph that as of April 15, April 5, 2013, maybe Mr. Abel can just clarify whether this was within or whether there was some difference in the way they changed something that the State would not have had in it's original RFA? Could you just comment on that?

CHARLIE ABEL: Yeah, I'll start and Becky can correct me if I'm wrong. HCR requested a lot of counties, expansion into a lot of counties, and because there's such a large dispersion of those counties, the CHHA program requires that you have a home base that is proximate to the counties that you're serving. So therefore the Department engaged the applicant and said, OK, you're going to have to break up your application into bite sized pieces that will establish a home base that is reasonable for the communities you propose to serve, and that's why we have multiple applications. And just – I'm sorry to delay this, but just a public service announcement here; the, when we implemented the NYSECON system, it's actually three systems. And one of the systems is the public view system which is specifically to improve transparency of the Department's actions and make that available to public health planners and the general public. It is available on the web. It is very simple to

use and rather robust, and it has from the very moment that this application, these applications were acknowledged has listed all of the specific counties that each application proposes to serve. And really that should be the place that people should go to look if they want to see what's being proposed in their county and be prepared to come and address the PHHPC when that application is proposed.

WILLIAM STRECK: So, I think we've covered this debate –

BECKY GRAY: Can I just add one other comment? I'm sorry. The RFA specifically asked each applicant to submit only on Certificate of Need application and further stated that it would be necessary, it may be necessary for the Department to have you submit additional CON applications if we were going to approve the application. We have done that a number of times. There has not been a date or a deadline associated with those additional CONs because it has been associated with the Department's work and our timetable as we've been able to complete our reviews.

WILLIAM STRECK: So, our discussion has I think approached some level of conclusion. There is a process that was followed. There have been questions raised about the communication process from the agenda to the data, and then we

have sited prior precedent. Is there more debate about that? If not, I'm going to ask Mr. Kraut to amend his motion so that we can deal with the core question, the HCR applicant group which I believe is the core question here, and then move from there.

JEFF KRAUT: So my understanding is there is a desire to remove the HCR applications as a group, all three, and bring them back to project review. So, --

ROBERT HURLBUT: Again, can you just, which by number?

JEFF KRAUT: I'm going to group them by – I'm going to make an amended motion.

ROBERT HURLBUT: Because there was only one application of the HCR group that was going to be taken out.

JEFF KRAUT: OK. So, I'm going to – so this is the amended motion. But I'm going to take all three out right now. I know, and if you don't want me to take all three out, vote down the motion. And we're going to have a recusal because Mr. Booth's going to have to leave when I do this. So, I amend my motion for application 131186C, HCR Clinton County with an interest declared by Mr. Booth and Ms. Hines. Application

131187C, HCR Madison County. Interest declared by Ms. Hines. A recusal by Mr. Booth who is leaving the room. Has left the room. And application 131188C, HCR Schoharie County. An interest declared by Mr. Booth, Ms. Hines. Mr. Booth is out of the room. To expand the certified home health agencies into the areas indicated in the application. My motion is to send those applications back to project review for reconsideration and public comment to be brought back to the Council at it's next meeting.

WILLIAM STRECK: Is there a second for that motion? There is a second. Now, is there debate on that motion?

HOWARD FENSTERMAN: Yes. I just want to ask my establishment chairman, are you supporting that motion? Because you just made it.

JEFF KRAUT: I support that motion given what I feel is the tenor of the Committee. The preference of the Council. Yes. I do support it.

[so you go with the flow]

JEFF KRAUT: Yes.

WILLIAM STRECK: We won't go that far. Is there more discussion on the amended motion by the Chair of the Project Review Committee. Mr. Hurlbut.

ROBERT HURLBUT: The applicant followed the rules. And we're setting a precedent here to send it back. The fact we're even sending back the one county one, I just don't understand this. I mean, are we at the 11th hour going to question it because you have some people sending in letters, and then a union sending in letters, they're absurd. I mean, are we going to kowtow to this? Is this fair to the applicant that did it the right way? I mean, just, what are we doing? It's not right. I mean I'm not in perfect agreement with everything this council does, but this is really bad. We're setting a precedent here that at the 11th hour we can change everything. And I just – and I'm just – Mr. Chairman I'm surprised that you would actually say that you're actually in favor of this. Usually you take a neutral position. And to let us decide. And I just.

JEFF KRAUT: Well, Mr. Streck is chairing the meeting.

ROBERT HURLBUT: Yeah, but you're the chairman of the Committee, and it's very unusual for you to do this.

JEFF KRAUT: Because I believe – listen, if what I've heard and this is the only way to determine, from the majority of the people believe that that should be done based on the comments, I will go with the majority. I will speak my mind. But I am supporting it.

GLENN MARTIN: I just have to object to the last comment in terms of kowtowing to anyone. I mean, I understand the Committee made a recommendation going to the full council. There were letters submitted in a timely and appropriate way that were distributed to the Council that raised issues that basically said there wasn't a fair hearing at the Committee level through no fault necessary of anyone, but that's sort of the allegation that occurred, and now they're asking the Council to make the judgment that the Committee was unable to make a full determination properly because not all the evidence was presented, yada, yada, yada. And that, the Council to send it back to the Committee. There's nothing particularly wrong with that or nefarious or anything else. So I object – I'm sorry (Mr. Hurlbut) I object to that assertion because what we're doing here is fine if we do it.

WILLIAM STRECK: Is there additional comments on the motion?

ART LEVIN: Point of information to Dr. Martin's statement. Is the allegation that the Committee didn't have all the facts?

JEFF KRAUT: Mr. Levin, I just want to make a point. From the transcript of the meeting we asked, does any member of the public wish to be heard, and no response was given.

WILLIAM STRECK: Mr. Fensterman.

HOWARD FENSTERMAN: I just want to frame the issue, because it's really not that esoteric for us. This is really what we call in the law practice a due process issue. We're not talking substantively here about any of the issues that are before us. It may very well be, but if this thing is sent back, the same result is going to occur. We're not talking about substantive issues here now, and certainly, and I think the commissioner – it is the commissioner, it's his decision – but he's certainly correct. We cannot take letters and arguing after the fact about substantive issues, and the real issue is here, were the folks who have submitted objections provided their "due process" to come forward before the Establishment Committee and raise the questions that they would like to raise? Not that we would necessarily subscribe to those objections. And the big difficultly that I think we're all troubled by here is that we

have a precedent now. We have a precedent. This has occurred now in the past. We've been doing it this way. There have been other applications that have come forward where the applicants were treated in the same manner as this applicant has been treated, and the public was treated in the same manner as the public was treated in this application. And we did not find in those instances, perhaps because there were no objections sent to us that there was any issue of due process. So, we have a precedent that we've done it this way before, and I think one of the problems we're having is that now some objectants have raised due process issues and claiming that they weren't on notice. So, this is a very, very difficult issue. That's why, and I disagree with my colleague, Mr. Hurlbut, I'm influenced by my Establishment Committee chairman on this, and I disagree with you respectfully Bob, that I think that given your history of experience versus SHRPC and now here, you know what your view is on this. I appreciate that you made the motion, but I really – is your view what you articulated earlier about it being that their charged with the notice?

JEFF KRAUT: I still believe – I'm trying to defend the process of the Committee. And I don't think personally, but I do recognize that Ms. Hines made a point. This was never done before. It was broken up into three applications. That could have caused a process breakdown. I'm willing to do it. I

appreciate your comments, but I do not need to be loved either. So it doesn't motivate me. I'm just trying to deal – I've always what's fair and you raised the point without being repetitive if there's a feeling that this wasn't done fairly, fine. We'll send it back and we'll do it fairly.

WILLIAM STRECK: And now knowing that the last two comments are going to be the most important ones, I want to try to bring our discussion to a conclusion. Dr. Brown.

LAWRENCE BROWN: Well, I thank you, Chair for attaching that significance to my comment. And my esteemed colleagues I appreciated that as a lowly physician I don't know much about due process. But to me this is a substantive issue. I am concerned about the health and the public health of the citizens of the State of New York. And I'm concerned about the extent that there was no error and process, even though I appreciate my colleague about the concern, I must confess, I really would side on the direction of this is, has been our process even though this is unique in some ways, I really believe that this may very well have some issues with respect to access to care or the quality of care. I really have some concern from a public health standpoint. So I really, unless there is some can share with me that the public health is better served by a delay, I have real serious concerns about changing this.

WILLIAM STRECK: Additional comments? We're looking for one – Mr. Robinson and Dr. Bhat. Both of you have not spoken so you'll get your day.

PETER ROBINSON: I actually think this is frankly a little bit more about substance than process, and I think that clearly there is a constituency that views the inappropriateness of this sort of dramatic expansion in CHHA licenses to implement MLTC and there is, I think, still a real question about whether or not this strategy for achieving the goals that the Medicaid Redesign Team has put in place is the right one. Nonetheless, it seems to me that that question has been asked and answered and the process is underway. And so both from the standpoint of sticking to process and the fact that the policies have already been implemented and this application has gone through the same standard of review as everybody else's has, I don't see the value in moving it back to Establishment. And I think we need to move forward here.

WILLIAM STRECK: Dr. Palmer.

DR. PALMER: Thank you. I'm going to support moving it back because I think there's another P word here that's as important. It's the practice. The practice was changed. The

process is in question because the practice was changed as directed by the Department. So I think it needs to be moved back and another look be taken. Thank you.

WILLIAM STRECK: Is there further discussion? OK. So, following Robert's rules of order, we have a series of votes before us. The first is there is a motion to amend the motion that has received a second. That motion to amend the motion has been made by the Chair, so could I first call – and then we will vote upon the amended motion after we grant the privilege of amending it. So the first vote is for the group to concur with amending the initial motion. So for that vote I would ask is there discussion? If not, I would ask for those in favor of amending the original motion to please vote aye.

Aye.

Opposed?

Nay.

OK, we will now go to the more physical act of raising hands. So those in favor of the motion to amend the motion please raise your right hand. Motion to amend the motion. So the motion to amend the motion does not pass. So, we are now

back to the original motion which is to move the groups sans Madison.

[which you are required to bring Mr. Booth back in the room for]

So, Mr. Booth may return to the room for that.

[want to bring him up to speed]

So, little hard to catch up here, Chris, but we basically had an amended motion which you were aware of, and that motion just failed. So now we're back to the original motion which is items one, three, and four. Which would include two of the HCR applications but not the Madison application. So, that was the original motion. It received a second. Is there a motion to – I will now call the question on that. Is there further discussion on that particular motion to which we have returned? Hearing none, those in favor of that motion please raise your right hand.

So that motion passes. Those three are approved. Oh, opposed?

Two. Two opposed. Three. I'm sorry? The motion was to approve. There are 15 aye, 2 no's and an abstention by my calculation here. So that passes.

JEFF KRAUT: Now I've got to call application 131187C Madison. Thank you Mr. Chairman. Now I'd like to call application 131187C, HCR Madison County. An interest declared by Ms. Hines. A recusal by Mr. Booth. Mr. Booth has left the

room. This is to expand a certified home health agency program to include Oswego, Onondaga, Jefferson and Cayuga Counties. OHSM and the Committee recommend approval with condition and contingencies, and I so move.

WILLIAM STRECK: There's a motion and a second. Is there discussion on this application. Ms. Hines.

MS. HINES: So I won't repeat myself, but I just need to make the same comments for the record related to this application. And I have to say I think Mr. Fensterman did a much better job at articulating it than I did. I think we are doing a disservice to due process. This has nothing to do, in my mind, with what is right about the application approval and everything to do with making sure that we have public comment and visibility and transparency around that and I do not believe that happened. I just need to say that.

WILLIAM STRECK: Are there other comments? Those in favor of the motion as presented, please raise your right hand? So the motion passes. And the application is approved. I'm sorry. A No. Those opposed? Three opposed.

JEFF KRAUT: You can as Mr. Booth to return to the room. I'm now going to call the category one applications in a group.

I'm going to group the disestablishment of the Stellaris Health Network. I'm sorry. No, that's all right. I'm in these. Category one. I'm going to White Plains. Yeah, I'm moving on the category one, the applications for establishment and construction. We're out of these.

These application, because they don't go in the order – my script is different than his. We'll go with my script. OK. I'm going to the application for disestablish – the application 132025E, White Plains Hospital Center in Westchester County.

132026E, Northern Westchester Hospital, Westchester County.

Application 132027E, Lawrence Hospital Center, Westchester County.

Application 132028E, Phelps Memorial Hospital, Westchester County.

This is for the disestablishment of Health Star d/b/a Stellaris Health Network as an active parent and a cooperator. OHSM and the Establishment Committee recommend approval with condition and contingencies, and I so move.

WILLIAM STRECK: A motion and a second. Is there further discussion? Hearing none, those in favor?

Aye.

Little more enthusiastically here.

AYE.

Opposed? Thank you.

JEFF KRAUT: I'm going to batch the following several applications. These are applications for which there were no issues, recusals, abstentions or interests declared.

Application 132056E, Eye Surgery Center of Westchester County.

Application 062287E, SDTC, the Center for Discovery Incorporated in Sullivan County.

Application 131237E, B&L Health d/b/a All Health D&TC in Kings County.

Application 131258B, AIDS Healthcare Foundation in Kings County.

Application 13134E, Pala Community Care LLC., d/b/a The Pala Community Care in Kings County.

Application 131195E, River Ridge Operating LLC, d/b/a River Ridge Living Center in Montgomery County. OHSM recommends approval with condition and contingencies as did the Establishment and Project Review Committee and I move these.

WILLIAM STRECK: There's a motion with a second on the floor. Is there discussion? Hearing none, those in favor, aye?

Aye.

Opposed? Thank you. The motion carries.

JEFF KRAUT: I'm now going to take as a group certificates of incorporation amendment or dissolution. Certificate of Incorporation, the Hazel Thomas Holder Lung Foundation Inc.; Certificate of Amendment of the Certificate of Incorporation for the Foundation of St. Mary's Hospital at Amsterdam, Inc., for a name change; Certificate of Dissolution of the Linden Foundation, Inc. OHSM recommends approval as did the Establishment and Project Review Committee, and I so move.

WILLIAM STRECK: A motion and a second. Is there further discussion? Hearing none, those in favor aye?

Aye.

Opposed? The motion carries. Thank you.

JEFF KRAUT: I'm going to call as a batch the licensed home care agencies.

Application 2071L

Application 2001L

Application 2090L

Application 1615L

Application 1229l

OHSM recommends approval with contingencies, as did the Establishment and Project Review Committee, and I so move.

WILLIAM STRECK: Motion and second. Any discussion? Those in favor, aye

Aye.

Opposed? The motion carries. Thank you.

JEFF KRAUT: I'm now going to move the category two applications where there were no recusals. There was no decent by establishment of the Committee.

Application 132057E, Queens Endoscopy, ASC, LLC in Allegheny County. An interest declared by Mr. Booth.

Applciation 13129E, Planned Parenthood of Central and Western New York, Inc., an interest declared by Mr. Booth.

Application 132065E, Plattsburgh Associates, LLC, in Clinton County. An interest had been declared by Dr. Bhat and Mr. Booth. OHSM recommends approval with conditions and contingencies as did the Establishment and Project Review Committee and I so move.

WILLIAM STRECK: Moved and seconded. Is there discussion? Hearing none, those in favor, aye?

Aye.

Opposed? Thank you.

JEFF KRAUT: Now going to move the following, the one application. There is, actually, there'll be a conflict and recusals on these. So, application 131107E, JSSG Health Care LLC, d/b/a Fiddler's Green Manor Rehabilitation and Nursing Center in Erie County. A recusal by Mr. Fensterman who is leaving the room and an interest declared by Mr. Booth. This is to establish JSSG as the new operator of Fiddler's Green Manor Nursing Home. OHSM recommends approval with condition and contingencies as did the Establishment and Project Review Committee and I so move.

WILLIAM STRECK: Moved and seconded. Discussion? Those in favor aye?

Aye.

Opposed? Thank you. The motion passes.

JEFF KRAUT: I'm now going to call the next two applications where Dr. Bhat has issued a recusal. Application and Mr. Fensterman. Application 131120E, Essex Operations Associates LLC d/b/a/ Essex Center for Rehabilitation and Healthcare in Essex County. Dr. Bhat and Mr. Fensterman have recused themselves. There's an interest been declared by Mr. Booth. To establish the Essex Operation Associates as the new operator of Horace Nye Home. OHSM recommends approval with condition and contingencies, and application 131193E, Washington Operating Associates, LLB, d/b/a the Washington Center for Rehabilitation and Healthcare in Washington County. Recusal issued by Dr. Bhat and Mr. Fensterman. To establish Washington Operating Associates as the new operator of Pleasant Valley. OHSM recommends approval with condition and contingencies as did the Establishment Committee and I so move.

WILLIAM STRECK: Moved and seconded. Discussion? Those in favor, aye?

Aye.

Opposed? Thank you the motion carries.

JEFF KRAUT: OK. If you can ask Dr. Bhat and Mr. Fensterman to return. I'm now going to call application 132079E, Auburn Senior Services Inc., in Cayuga County. An interest declared by Mr. Booth. To establish Auburn Senior Services Inc., as the new operator of the Cayuga County Nursing Home. This is a companion to application 132093, which I will call in a moment and establish (Loretto) Management Corporation Inc., as the active parent and the cooperator or Auburn Senior Services.

Application 132093B, Auburn Senior Services of Cayuga County with an interest declared by Mr. Booth to establish the Auburn Senior Services as operator of Mercy. Establish Loretto Management Corporation as the active parent and cooperator. To renovate and expand Mercy adding a 60 bed wing for a total of 300 beds to accommodate transfer of beds from Cayuga County Nursing Home of the application I just referenced to 17 RHCF beds will also be decertified through this project.

Application 131281B L. Werner Inc., d/b/a HCR of Washington County. An interest declared by Ms. Hines. To establish L. Werner as the operator of the Washington County Public Health Nurses Services CHHA and long term home healthcare program.

And application 2242L, Mt. View Assisted Living as a licensed home care agency. OHSM recommends approval with contingencies and conditions as indicated in your report and as did the Establishment Committee as well and I so move.

WILLIAM STRECK: Moved and seconded. Further discussion? Hearing none, those in favor aye?

Aye.

Opposed? Thank you. The motion carries.

JEFF KRAUT: I'm now moving to the category three applications recommended for approval where we had a committee dissent but no recusals.

So, application 13103B, Bay Ridge Surgi Center LLC, in Kings County. To establish and construct a two specialty freestanding am-surg center providing gastroenterology, pain management to be located at 370 Bay Ridge Parkway in Brooklyn. OHSM and the Committee recommended conditional and contingent approval with an expiration of the operating certificate five years from the date of it's issuance was recommended with one member opposing.

And application 131308B, Great South Bay Endoscopy Center, LLC, in Suffolk County, to establish and construct a single specialty freestanding ambulatory surgery center to be located in Suffolk County with conditional and contingent approval with an expiration of the operating certificate five years from the

date of it’s issuance was recommended with one member opposing and I so move.

WILLIAM STRECK: Moved and seconded. Discussion? Hearing none, those in favor aye?

Aye.

Opposed? Mr. Robinson is opposed. The motion carries. Thank you.

JEFF KRAUT: Two more applications. I’ll take each of these separately. This is applications with Establishment and Project Review Committee where we had dissent.

Application for acute care service; 132088E, St. Lawrence Health System Inc., St. Lawrence County. An interest declared by Mr. Booth. To establish Gouverneur Hospital as the operator of the EG Nobel Hospital of Gouverneur and establish St. Lawrence Health System Inc., as the active parent of the Canton-Potsdam Hospital and Gouverneur Hospital. OHSM recommends approval with a condition and contingencies, as did the Establishment and Project Review Committee with one member opposing and one member abstaining, and I so move.

WILLIAM STRECK: Moved and seconded. Discussion? Those in favor aye?

Aye.

Opposed? Thank you. The motion carries.

JEFF KRAUT: Application 121373B, Lockport Ambulatory Surgery Center, LLC, Niagara County. Interest declared by Mr. Booth. This is to establish a multispecialty ambulatory surgery center to be located at 160 East Avenue in Lockport. This application was deferred at the August 1 full council meeting, return to the Establishment and Review Committee where it was once again reconsidered. OHSM recommends disapproval based on need and financial perspective. The Establishment Committee upheld the OHSM's recommendation of disapproval based on need and financial perspective with two members abstaining. And I so move.

WILLIAM STRECK: Moved and seconded. Is there discussion? Hearing none, those in favor of the motion as presented say aye?

Aye.

Opposed? Thank you. The motion carries.

JEFF KRAUT: Mr. Chairman, that concludes the report of the Establishment and Project Review Committee.

WILLIAM STRECK: Thank you Mr. Kraut.

With that I would ask for comments or questions from members of the Council on any of the topics we've covered? Mr. Abel.

CHARLIE ABEL: I'm sorry. I wanted to catch this before Mr. Kraut adjourned the Committee. We have a strong likelihood of having to have a special Establishment and Project Review Committee and PHHPC meeting. The Department is reviewing three applications submitted by Montefiore Medical Center to have a subsidiary entity take over and be established for the operation of Soundshore Medical Center, Mt. Vernon Hospital, and Schaefer Nursing Home. The Department's been working with the applicants over the last few weeks and there are still some critical – as of last night, some critically needed information from Montefiore. Montefiore has verbally told us that they will be submitting that information very shortly. The critical nature of all this is that before I think it's October 26 is sort of a deadline, it is a deadline with respect to these transactions, and the Department believes that we will have a review ready for

the Council in the interim period, hopefully by in time for a meeting perhaps end of next week, early the week following in order to have an orderly review of that, these applications respond to public input as well as the Council's input, and allow the applicants assuming they get approval, to submit contingency responses in time to make these deadlines. We will be reaching out to members assuming we have all we need to be able to complete our review. Over the next day or two we'll be reaching out to members to find out who's available what days. The method for conducting this meeting we believe can be similar to the bath salts meeting we had earlier in the year by video conference from remote sites having public sites available here and in Albany. So I just wanted to make sure that you folks understood where we were with this and what may be potentially asked of you, and at the same time give the public as much notice as possible that we may be entertaining these applications in the public forum within the next week or two. Thank you.

WILLIAM STRECK: Charlie, when you say entertain the public, is that a Project Review Committee meeting – an Establishment Committee?

CHARLIE ABEL: Our expectations is that we'd have an Establishment and Project Review Committee followed immediately by the full council.

WILLIAM STRECK: Yeah, a little due process oriented here today, based on our discussion. Is there a time table for communication of the public? I mean, we're talking about two weeks for three major take-overs – just be cautious.

CHARLIE ABEL: Obviously the applications and their descriptions are up on NYSECON, but we expect to be – we want to be able to give the PHHPC as well as the public approximately a week to review the exhibits in detail so we're hoping to have those exhibits posted approximately a week before the actual meeting.

WILLIAM STRECK: So we have no legal time limits that are out these in terms of a week or 10 days or anything like that as far as we know? I mean, a week sounds –

CHARLIE ABEL: The minimum public notice period is 48 hours, and I can be corrected by any of the lawyers up there in Albany, but our customary, what we try to do on a customary basis is a week advanced notice to the general public.

JEFF KRAUT: So, you'll give us notice – I mean, look, you know, it's important if this hospital is taking over this hospital to make sure things happen so it's uninterrupted, but at the other hand, so I would say, you think we'd be notified maybe tomorrow of the date? Just to get us –

CHARLIE ABEL: That's my hope. Obviously we'd be pooling the group with respect to availability.

WILLIAM STRECK: Dr. Brown, I'm sorry.

LAWRENCE BROWN: Can you – I apologize. I am trying to get my – wrestle with issue, what is the urgency why this is – can you repeat that again? If you have already, I apologize.

CHARLIE ABEL: These three facilities, Soundshore Medical Center, Mt. Vernon Hospital, and Schaefer are currently part of a system that is in severe financial distress and at risk of closing. And Montefiore Medical Center has submitted to the Department a three CON projects for each of those facilities to have a subsidiary of Montefiore be established for one for each of those entities. And it is – this is part of a structured bankruptcy proceeding. It is expected that – and there's, it's been portrayed to the Department that there is a real deadline for making this happen, and the deadline is October 26.

LAWRENCE BROWN: Has the Department received any communications from individuals or entities outside of Mt. Sinai or the three institutions that suggest or underscore the urgency of this consideration?

CHARLIE ABEL: I'm not aware of any material that we've received that seeks to oppose these projects.

LAWRENCE BROWN: Mr. Chair, I certainly have no reason to in fact have any objection to the recommendation of the Department of Health, but I, you know, this type of notice, I really wonder if this really is serving the public. I mean, now my colleagues, the attorneys about the due process, I know nothing about that, but just as a citizen, having this amount of notice seems to be a bit disconcerting to me.

CHARLIE ABEL: If I can respond. We do typically post the agenda for an upcoming Establishment and Project Review Committee a week before the meeting date, and so we're seeking to keep with that advance notice.

WILLIAM STRECK: And the 26th, Charlie, just to Dr. Brown's point, is this a fiduciary deadline in terms of other agencies or is this our own?

CHARLIE ABEL: It's not our deadline. It is driven by the transactions associated with these purchases from bankruptcy.

WILLIAM STRECK: Are there other comments or questions on this? Keep your cell phones are. This is obviously important, but this will be delicate to assemble the group in substantial enough number to provide the input we want. Nonetheless, we appreciate the notification and we are on alert.

Is there other information to come before the group today? We will need 13 members to reach a quorum and then we would have to reach the higher standard of majority, I mean an absolute vote from all 13, so we need more than 13.

JEFF KRAUT: And I need seven on Establishment for to pass a vote up to the Council.

WILLIAM STRECK: OK. So that's our aggregate task is to present ourselves for these deliberations.

ANGEL GUTIERREZ: I'm sorry, I had to step out for a minute. Is this something that we're going to have to do in person, or can we do remotely?

WILLIAM STRECK: Teleconferencing, but not phone. Phone won't work. It has to be a teleconference. Video conference. We can't do it just by telephone.

So, Buffalo, Rochester, Syracuse, Albany, and Manhattan sites for the teleconference, the video conference. I beg your problem.

ANGEL GUTIERREZ: And the target date is what? I know 26 is the deadline, but are we going to do it before that?

WILLIAM STRECK: Late next week or early the following week for out Council, or for one of our groups. Well, for both groups because we're going to meet the same day. So, late next week; early the following week. I think that's what you said Charlie? Is that correct? OK, is there other business? Colleen? Are we clear? Jim, any questions, comments? There is a health planning meeting, perhaps a brief one to follow, and with that I would entertain a motion to adjourn. Thank you. And there is lunch next door for the Council members. Thank you for your time.

JOHN RUGGE: For members of the Planning Committee or whoever would wish to stay, I think we can accelerate tomorrow's meeting if we meet for briefly to go over introductory – so have a (slice of pizza and get started.)

[break]

JOHN RUGGE: …facing would be helpful and we have that now with Dave Chokshi's first draft of, I think, a remarkable paper, pulling the elements, what Joan was able to collect were a whole series of documents, starting with our CON report from last year, extending to the charge to the— the request for information from stakeholders last February, to the option papers presented by our subject experts, and ultimately including all of our transcripts, which my secretary printed out, and they turn out to be an enormous stack. And somehow you digested all of this and it seemed to be helpful since we were meeting today as a council to come together to look at any edits or suggestions we might care to make to the paper. And it might be good after that for me to give just a brief overview of how I think tomorrow's discussion might, might serve us and how it fits into that larger, the larger agenda we are creating. But anyway, for starters, if there are any general comments, or we could go more page-by-page or topic-by-topic, with either omissions or restatements or any other changes people would like to see in this introductory chapter to our coming report? Chris?

CHRIS BOOTH: I liked it the way it was written. I think it's an excellent document for that purpose and I really didn't see anything that I would want to change in it.

JOHN RUGGE: Is there a ball game or something? The -- I did get, if I can find it. Jeff.

JEFF KRAUT: One of the issues in, in fact, I can't find it here, but it's about the possibility of accreditation of some sort, you know, whether it's national accreditation or state. Did we have a conversation and a discussion about that? I'm -- I don't know if I'm melding multiple documents. I don't know if it was in his or another one that was referencing--

JOHN RUGGE: There was discussion in accreditation in the context of the mini-retail limited-service clinics, and I think that spilled over into Dave's treatment.

JEFF KRAUT: OK, cause some of the minis use the American Association of Ambulatory Care, right, to… for accreditation?

JOHN RUGGE: Right.

JEFF KRAUT: OK.

JOHN RUGGE: Right.

JEFF KRAUT: And the concept here, and I don't know if this is the right place, John, is in the integrated behavioral health, do we need to make any reference to the integration of article 28 and article 17? So there's, you know, our CON structure, our regulatory structure, actually is antithetical to this policy initiative. Cause we, we license mental health separately from primary care; although you can have primary care mental health. So is there something that we want to have, kind of a broadbanded—and maybe that comes out of the second phase of the conversation. I'm not sure if it's— It's certainly not appropriate for this.

JOHN RUGGE: Right.

JEFF KRAUT: It just, it -- that was one of the notes I wrote when I read his section on integrated behavioral health. That's all. So maybe just an issue to put in the garage.

[inaudible]

JOHN RUGGE: As we discussed, the mini retail clinics, we, at our regular committee meeting last month, reviewed the work that DOH had done in submitting a legislative proposal last

year and we’re looking especially for themes or recurring items that would be applicable to other parts of the ambulatory care system. One of those was accreditation, of not the State itself doing a survey or doing direct oversight, but looking for some other body analogous to the joint commission for hospitals.

[inaudible]

JEFF KRAUT: [Office-based.]

[inaudible]

Use your mic.

JOHN RUGGE: Microphone, Art.

ART LEVIN: Are we gonna wait until we’ve seen application after application for new arrangements to do, you know, ambulatory surgery in settings that aren’t, you know, that don’t want these single doc offices paying all the price for accreditation of, you know, with a national organization RATHER THAN sharing that or becoming an article 28 facility, from what we’ve seen here. So we’ve sort of start out by saying this is an unregulated environment, that’s bad, we think, we need to bring it under the umbrella of some sort of oversight. The State

didn’t want to get involved, so the idea was, OK, use national certification, and there were three or four available, and then we find out that it’s an expensive little goodie for people and so they run away from that setting now into a different setting and we don’t really have any sense of whether that’s better, in terms of the things we are concerned about, or worse, or the same. So I just think we have to be thoughtful.

JEFF KRAUT: I agree.

ART LEVIN: And, you know, it’s sort of a knee-jerk reaction in the old mode, OK, we need some sort of oversight, the State doesn’t want to do it, better some sort of national certification body or an accreditation body than no one. But what are the consequences of that and we need to think it through. I just…

ELLEN RAUTENBERG: Using that example, you know, we were clearly told, and I can picture Jim Kline doing this, that ambulatory surgery was cheaper and higher quality, so that the evidence existed at that point to help us make this recommendation, so I think that we need evidence before we go down the path of regulation and other things here, because we know little and we admit we know little about these alternative providers.

JOHN RUGGE: I think that's another theme that emerged from our discussions and that is we're at the stage now where we have new data available in a way never before and then we can, we can look for reporting of that data so we can understand it and then in the next iteration of policymaking, come to better decision about what makes a difference in terms of either regulation, or naming, or accreditation, or whatever, but we're not ready -- but the initial incremental step is to get the data.

ELLEN RAUTENBERG: And it's also compared to what? And we know we're not talking about getting data from private doctor's offices, we're talking about getting data from the sort of middle ground compared to article 28s.

[Well….]

ELLEN RAUTENBERG: And so, I'm just saying, we're not… we're not comparing apples, oranges, and bananas.

JOHN RUGGE: But at least it's certain kinds of private-practice settings we may be—office-based surgery, for example, may well be susceptible to reporting requirements, and so it…

ELLEN RAUTENBERG: I meant for primary care.

JOHN RUGGE: …any kinds of private practice, but for certain kinds of service categories, we're looking for information in a way never before available.

JEFF KRAUT: Yeah, and I think it was Dr. Gottfried… Assemblyman Gottfried. Honorary doctor, and I am sure he has one, but I think it was Assemblyman Gottfried who kind of gave us a warning to that point, saying you know, this is in fact licensed—these are physician practices, these are not under the purview here. This is — I think he called it article 6 in the Education— SED, or— these are article 6 facilities, which are licensed by SED. You are essentially, you're— you should be careful about regulating the private practice of medicine. And I think our conversation was—and I am not saying regulation, but making sure the public was aware that that is the private practice and if you use the term "urgent care" or "immediate care" or "convenient care," there is a certain requirement, because of the issues here. Because it's a discontinuous—it's not necessarily continuous—should we obligate them to make sure that that data is, there's referrals to primary care, the data is electronically available, and it's a grey area. I think—

ART LEVIN: So, with all due respect to them, the office-based surgery legislation was a response to the fact that we couldn't regulate— I mean, we found a way to sort of get hooks in there, right? We knew we couldn't regulate and the department legal, the legal department said you can't regulate. You know, we've looked at all of this, the only tools available to you are physician discipline, article, you know, 230, and one other. I can't remember. So we have two arms, right, we have the reporting requirement, which is, comes under 230 THAYER report, right? And we have the accreditation, which I don't know what it comes under, but it didn't run into that— it didn't run into that road block, SED territory, don't mess with it.

JOHN RUGGE: Let me jump forward a little bit to where I think we are going to be going tomorrow and this is a background for how Dave has done his paper, because I share with him my impressions of how this is. That rather than the question of accreditation or reporting, the focus of our effort is how do we create a seamless non-duplicative series or spectrum of ambulatory care services and what should they be? How many categories are there? And how do they overlap or connect between private practice and institutional practice? And it seems to me that the group largely accepted the premises and the characteristics enumerated by DOH regarding the retail clinics. I didn't hear any objection to the constructs. When we had the

presentation from Chandler Ralph and them from Liberty last month, there seemed to be actual enthusiasm for the freestanding EDs, including part-time EDs, so there are two sides of the spectrum. You've got the extremes, if you will. And then in the middle, we have private practice of medicine, office-based practice. We have the clinic structures under health centers, FQHCs, all under article 28. And our last meeting was talking about, well do we need another category of "upgraded" for those. I think the key point is we've got two modes of doing office-based care—entrepreneurial practice, under the educational license, and article 28 under, under the Health Department. And as we looked at the, what an upgraded D&T is, on the one side, there are FQHCs clinics that, as a term of art, are now being called "nationwide mega-FQHCs." There are some really big FQHCs and they are strong and they do a lot of services and they bundle a lot together. And in that way, these— we have an institutional equivalent to the mega-practices, right? Up to now, they are not being regulated than any other health center or article 28 D&T. But an interesting parallel is another aspect when we look at what "upgraded" means in regulation—not that any has ever been operationalized—in regulation upgraded means having quote "limited emergency services," which I take to be urgent care. Limited, they are emergency, but it's limited. It's urgent care. And therefore, what I wonder is whether the outcome of that discussion—and Glen was very— is this an answer in

search of a question, is there a need for such a thing. It seems like rather than having a designation of an upgraded D and T; what we are really calling for or implying is a category on an operating certificate that says “urgent care.” And so a clinic could have, could be labeled as urgent care, not as an upgraded D and T, but just another service that clinic provides. But likewise what we are saying in the field is all kinds of providers, some of them very small, but certainly essentially all the mega-groups, are offering urgent care as a bundle or a package of services that has sprung up and have not been particularly recognized, or accredited, or looked at and if we are looking at creating that, that spectrum, I think what we’re talking about are like five categories: we have the mini-retail clinics, limited service clinics; we have office-based practice or article 28 licensed clinics, D&T centers; moving up the scale, or around the scale, urgent care, yet to be defined, that’s tomorrow’s agenda; and then the freestanding EDs, be they part-time or full-time. And if you have those categories, then you begin to, you will make sense of the world and know what it is and then begin to create expectations of what you would expect in any of those kind of categories. And, as another theme, we have talked about the need for common nomenclature in not labeling something in ways that are confusing to the public and… and have really no meaning because it’s simply a word. And so, and it seems like the pivotal, the pivotal category is

urgent care, because that too has both an article 28 mode and a private-practice mode, and is straddling those worlds of the ED and primary care with risks. The benefits, as we have been enumerated, is to keep people out of expensive, more expensive ER settings when they don't need to be there, but the risks are they are displacing or replacing primary care practices that are really a better mode of doing care. And so, and so it seems like our job is to, is to define those categories, look to require common nomenclature, and then decide about what kind of reporting is possible in this day, so that a few years from now we'll have much more data and do a yet-better job managing expectations. Glenn.

GLENN MARTIN: As you were talking, and it's still, I can't get past the fact that I still don't understand what urgent care is and it still, it seems to me, it's what a good primary care doc would provide you if you were his patient.

JOHN RUGGE: I would…

GLENN MARTIN: If I were feeling ill, I would call my doctor and I said, "I really feel like crap today, I gotta see you." He'd say "come on in," and he would take care of me. And if I don't have a primary care doc, I go to something called an urgi center that provides nothing more than my primary care doc

would do, assuming he can get labs and X-rays the same day, which my guy can do. So I don't, again, until we define what that urgi care center is really tightly it seems to me that's not… it either fills the gap or it is the cause of the problem, and I'm not sure which it is.

JOHN RUGGE: Yeah. And to answer that, that's what tomorrow's agenda— I'd agree. If you recall in Rochester, urgent care was a discussion we were intending to have after am-surg and radiation therapy and the rest and we were really confused. I mean, we heard the presentation and we didn't know what to do with that, cause it is— we asked what makes it such a pivot. We don't know what to do with it. The approach we are taking tomorrow is that we have two urgent care providers coming. One urban, unless you are from New York, in which case, Albany is regarded as rural; and the other rural, which is Lake Placid, or Saranac Lake, unless you are from Keene Valley, in which case, that's considered urban. One more-or-less urban and one more-or-less rural sites telling their story in ten minutes, so that rather than having an abstract policy discussion, at least we are grounded in two physicians' experience and how they are connecting to the rest of their medical community and the services they offer and what they would say of interest. They contacted me because they are forming a state association of urgent care centers. So here is a new, a new association forming

confirming that we think and have recognized there is an emerging thing out here that, so far, we have not had any structured consideration of. So starting with that, and then in addition, Joan and her staff have prepared a presentation of strawmen. The definition of urgent care, alternatives by way of reporting and regulation and accreditation that we can work our way through. So rather than trying to do that today, this is simply saying if we can, if that— if that helps to make sense of why we are doing the introduction this way. I described this to Dr. JOSTLYN, this is what we have done so far, this is where I think we may be going. Our next big discussion is on urgent care and we need a paper that helps us to understand the, the world as it is and the world as it's changing and the demands made on us as providers, as payers, as public officials. And, and hopefully by the end of tomorrow we'll have answers to all of Dr. Martin's questions. What is urgent care anyway?

PETER ROBINSON: So, John, I— One of the things that we need to factor into this process of figuring out what is what, is both coordination of care and cost. And to me, the issue of urgent care centers, or the potential proliferation of other than the downsizing-hospital freestanding EDs, is one of, is one of just more escalating costs. In other words, ambulatory surgery centers—the reason I oppose the two applications that came up today was, we're not changing the services at all, all

we are doing is providing a mechanism for higher reimbursement. Urgent care tends to be more expensive than what, when, what Dr. Martin was suggesting when he calls up and goes to his doctor cause he’s not feeling well. There is, there is that, that component to it. There is the need, and I was actually in the urgent care business at one point, there is the need to turn ancillary services that actually drive alternative aspects of care delivery in order to make those things work economically. And here we are in a, in a state and in a county where we are trying to drive down costs. And what worries me about this is not the fact that the public doesn’t start walking with their, with their needs towards urgent care and these kinds of modalities, but, in fact, it’s whack-a-mole in some ways because we are actually just displacing costs and, in some cases, creating poor utilization and higher costs and actually kind of almost moving against the triple aim, to some extent. We are dealing with a Medicaid cap in New York State and, yet more people are coming on to the rolls that are being covered, but within that same cap. There’s a lot of downward pressure, and yet these kinds of avenues, it’s almost like you get a medallion to sort of charge a little bit more and actually put excess pressure on other elements of the system that are really the safety nets for what the public needs. So, I just worry about this sort of realignment actually being more expensive.

JOHN RUGGE: And again, I would only say as a committee or a council, we are not planning to invent urgent care, we're trying to understand what's happening there now and then decide what kind of new oversight or new requirements might be applied to, leaving open what the appropriate level of reimbursement would be. I think there is a very good argument to be made that primary care visit should connote a higher economic value than an urgent care visit, except for one thing. With extended hours, there's a q theory problems and inevitably, if you are going to give good service on a walk-in basis, there is going to be down time, and that has to be factored in to the economic equation. Clearly tomorrow we are not going to be ready to…

PETER ROBINSON: But, indeed, that's the issue with emergency rooms, too. You have to have a whole bunch of stand-by capacity, which is what drives the high cost of emergency room care. We drive volume out of the emergency rooms, we are actually gonna make them less efficient. And so it's not that a lot of those costs are going to go away. We'll drive high-cost payments out of it, but the cost is still going to be there; it's going to be a real issue, I think, in a lot of ways to maintain what we need in real emergency rooms as we pull volumes out of there. I think that's actually a potential threat to safety.

JOHN RUGGE: I could contend that I don't think it's stand-by time that costs so much in the ER setting, and I think it's the need for the availability of very high-tech equipment that's needed. And then that's married to an expectation that if somebody comes to the ER, there's one shot to get the right diagnosis and therefore to be definitive, one needs to use as much technology as needed. But I think in the urgent care setting I think you could make a case for looking at a required affiliation or connection or referral arrangements to both ends, both directions, to the ER for those people who clearly have a more-extreme needs, but also back to primary care, so instead of trying to make a definitive diagnosis at the time of that urgent care visit, it's making a provisional diagnosis and reconnecting that person back to their medical home. And that, that's a different model than saying well, this is simply a low-level ER, and I think that's what we are striving for in terms of developing this continuum.

PETER ROBINSON: John, I guess— so then why would there be, why would there be the need then for these, in these FQHCs, for an urgent-care designation if what we are talking about is essentially almost having a more of a walk-in capability within an existing primary care setting. I mean, why— isn't that what doctors are licensed to do now?

JOHN RUGGE: I think what we'll see tomorrow is we are not looking at defining urgent care as simply walk-in to a primary care setting, but there's a bundle of services that we're… we expect that they would be available imaging for that person to evaluate the possible broken ankle. We are expecting IV hydration for the dehydrated— the dehydrated patient who has gastroenteritis. We're expecting the ability to do skin surgery, repair lacerations. And those are not available there's not available in the typical internist's office, and that is certainly primary care. So there's a bundle of services I think that we can define that are overlapping with it, but still distinct.

MICHAEL FASSLER: You know, John, a concern, (next level up though,) you have the freestanding EDs. How do you prevent them from becoming a very expensive urgi center, in essence? You know, 'cause if you are looking for reimbursement, you'll take A LIGHT case and, you know, shift it that way.

JOHN RUGGE: And part of what, part of the thinking is then there needs to be a phase II to this activity. That what we are grappling with what are the best categories that we can design to describe the taxonomy of health care in an ambulatory setting. As another exercise, there will need to be an economic and financial assessment in terms of what's the appropriate

reimbursement and how do we prevent abuse. Some of that might well fall to us; others will fall to Medicaid— Medicaid and OHIP. Some will fall to our commercial insurers to determine what is the right, the right value. If we try to do all that, we will never come out the other end, but if we limit ourselves to saying we're describing the taxonomy, we're describing categories that now exist, but instead of having that proliferate so we have EDs, emergent centers, walk-in centers, convenient centers, urgent care, and regular old offices with extended hours, we're going to delimit it so you can get your hands on it, know what it is we are describing.

(HOWARD BERLINER:) CHRIS, do you think different rates these different typologies?

CHRIS BOOTH: There is an office, doctor's office visit rate; there's an emergency room rate; and there is an urgent care, which is in the middle. That is historic, that has been the historic practice. And originally the theory was that you were… should pay more for the urgent care because of the after-hours, the walk-in, and the fact that it would save significant money off of an emergency room. And as long as it was reducing emergency room, which was often was overcrowded anyway, that was a good thing. I think that the issue now is it's stealing from

the primary care physician and therefore it’s cost inflationary in my mind.

JOHN RUGGE: And given the conversation at the Committee, there’s been questions back to DOH, could we do a needs assessment for urgent care? And if we have too many, can we really have a franchising model for urgent care. And the answer I’m getting, at least from people like Chris Delker, ah, not yet. We don’t have enough data, we don’t know what we’re doing enough to do such a thing. Perhaps five years from now that will be possible. We can’t go that far because there’s just too much dynamism, too many internal expectations, and not enough information to say we can, we can delimit how many there should be. At least we can define what is and what we would expect in that package I would argue.

[As, as you were talking and going through the .]

Mic.

GLENN MARTIN: I’m thinking of emergency rooms, and it’s like all the— On one hand, at least on my end of the street for psychiatry and substance abuse and the like, you always talk about a single door. No wrong door. You know, they can wander in

wherever in wherever they are wandering and you make sure they get the services they need; they don’t need to know where they are going to go. It seems to me emergency rooms are that. you show up there, depending on what time of day it is—it could be urgent, it could be sub-urgent, it could be emergent, it could be anything—and the emergency room sort of gotta treat all comers the same way, even though, you know, you could easily say—not easily, but—this would be a walk-in clinic, this would be urgent, this would be emergent, this is this, but you don’t expect anyone to know that, because they are not physicians going in. And they sort of end up in one spot. So it’s, I mean, again, I’m just frightened about coming up, well, I know we’ll talk tomorrow, but promoting something that isn’t, it isn’t necessarily particularly good and still leaving the emergency rooms back where they were. You know, they are just flooded with people because you can’t kick them immediately into the three proper doors when they walk in because of EMTALA and all the other issues.

JOHN RUGGE: I think the value of a process like this, you get lots of contributions that aren’t expected and one expected was examples of what is being done in England. So that actually there could be five doors and there are wrong doors. You go in the wrong place for the wrong thing—if you have a little rash, you don’t need to go to the ER—and in England, the

national health service has public service announcements, ads about here's what you need to go to ER for, here's what you go to urgent care for, here's what you see your doctor for, where's what you do for self-care, and, oh yea, in England, here's where you go to the pharmacist. So, these are really neat, very clever ads, and so once we have the designations, then we can do public education to say, don't go to the ER inappropriately, go to the right place and here's why.

HOWARD BERLINER: If I can say this before I suspect Dr. Boufford is going to say this. I mean, in England, you have, I mean, an effective and functioning primary care system that affects everyone so that, I mean, you're dealing with.

[JO BOUFFORD: I THINK IT'S GOING IN OUR DIRECTION.]

HOWARD BERLINER: I mean, you are dealing with some outliers and you might want to redirect people to more efficient or less efficient places, but that's not the situation we're dealing with here, both on the emergency-room side where people are going because they know they will get care, independent of the ability to pay, and I suspect, I mean, with the ACA and if lots of people choose bronze plans and they have 40% copays, I mean they are going to be looking to get care quickly and as cheaply as possible. And maybe that is urgent care, I…

JOHN RUGGE: But I think, also, this is probably of interest, one of the urgent care centers we'll hear about tomorrow was built as a component of the St. Peter's system in Albany, where they felt they had a primary care system already, but need an urgent care walk-in safety valve. The other is an urgent care system that was opened, if you will, in competition with the ER, of Chandler Ralph of Adirondack Medical Center in Saranac Lake, and as an outcome, he has developed a primary care practice, because he need to put some of these people who started an urgent care. And so we're seeing changes in many different directions and we can't mandate all the right things, but at least we can, number one, understand them, and then I think begin to categorize and over— once you have the categorizations that are clear, then begin to incent behavior through copays, reimbursement levels, public education, and the rest. And that, that's the incremental step that I think we can take, where it's impossible to solve everything. We're not suddenly going to invent a primary care .

PETER ROBINSON: John, I think, I don't disagree with that. I would just say that while we can't mandate, you know, where the market is going to go, we can certainly incent it. And that may be something that we can only recommend, I don't think we have the power to set reimbursement rates or to indicate what

we’re going to pay more for or what we are going to pay less for in order to create those incentives. But I think…

JOHN RUGGE: Well, what we’re trying to do is help Chris Booth get the pricing right.

PETER ROBINSON: Chris Booth is a good man and he should be, he should be supported.

[laughter]

[Howard Berliner: Just pay more.]

PETER ROBINSON: Chris. Chris does well by, by the Rochester region, at least I can speak to that. I… so I think we actually need to think about that, too. That’s what I am worried about. I mean, I think we are sort of on a path of sort of recognizing where the market is taking us and I think there is some reality to that and we shouldn’t ignore it. And some migration of the way care is delivered is appropriate. We need to, you know, reflect changes in technology and how people access services. But there is also, you know, a drive to also contain costs as we are doing this and we need to sort of, we need to be thoughtful that in just following the market we don’t, we don’t inadvertently create the wrong incentives.

Is what I am getting at.
So, let's make sure that as we make our recommendations we not just look at the settings of care and what people want, but also what drives them to the right places.

JOHN RUGGE: Right. But, in that setting and in answer to a couple of comments. I think one can imagine a legitimate role for an urgent care center as an alternative to the ER. Ten o'clock at night your kid is sick and your doctor is just not, doesn't have open hours. You are out of town, and have, and have a minor laceration or a puncture wound, where do you go? If that community has an urgent care center, that becomes a place to go. So I think your doctor truly is fully occupied and then, again, you have the laceration or you have the high fever. Now, I think there is a, there is a role. If in Buffalo it turns out we have 1,000 urgent care centers and hardly any private doctors we know we've got it wrong. But then other— then some other kind of intervention may be necessary, but I don't think that is because we would be wrong in defining what urgent care is and trying to identify what the bundle of services are and track it and monitor over time. Some— Dr. Gutierrez and then we'll get the…

ANGEL GUTIERREZ: You mentioned Buffalo at the end and [laughter], but I was raising my hand before that because I, I…

I see the urgent care situation from a different perspective in a way. You may want to call me a regulator. I hear the complaints about alleged misconduct that occur at urgent care centers, and when I try to pin down the providers as to what exactly happened, what I hear is excuses: I'm not a regular practitioner; yeah, I know that I saw Joe Blow ten times, but I am not the primary care physician; yes, I tried to refer him to his primary care physician, but he didn't have one. And when I say, "so who is doing the primary care in this patient," who is taking care of the health maintenance issues that Joe Blow has? Did he have a rectal examination done? Do we know, has he had a colonoscopy? Has he had a Pneumovax, and they slip out because they are protected by the fact that they are a private practice. From my standpoint, I would like them defined and regulated.

JOHN RUGGE: And in that respect, there's an interesting possible precedent in the proposal for the mini-clinics, and that is no more than four visits without a primary care visits. You can have more, but you won't get paid for more. So there's a way of, in effect, enforcing referral back to the primary care side so that, so that regular care—I didn't say routine—regular care is assured. So that becomes one possible mechanism for, for making that work. Art?

ART LEVIN: So, I mean, I know, to (Ellen's) point we have a big gap in available data. What— do we know anything that is fairly accurate about what these urgent care centers are seeing in terms of patients and conditions.

JOHN RUGGE: Yes, I think we can hear about that and we also have numbers. There are 650 urgent care centers in New York, for example.

ART LEVIN: Cause that would really be helpful, I think.

JOHN RUGGE: We will have presentations on exactly that tomorrow and also the National Association of Urgent Care will be here tomorrow to state their case and indicate the facts as they know them for what they regard to be urgent care.

ART LEVIN: So is this considered a growth line of business by people like Walgreens where these things are—? I don't know the relationship, but I know up in Greene County, you know, now…

JOHN RUGGE: CVS. CVS has 17 so far in New York.

ART LEVIN: OK. And they are part of Walgreens or it's…

JOHN RUGGE: It’s CVS. Different pharmacy chain. So this is definitely…

HOWARD BERLINER: But Walgreens is doing just that in Staten Island.

MS. CLEARY: I just wanted to clarify though, I think with the retail clinics they’re established as independent physician practices, within CVS, Walgreens, and all, to get around the corporate practice of medicine, so, just to clarify.

JOHN RUGGE: And to be clear, we have two representatives of the law tomorrow to help us. Legal advisors one by, by remote control and one in… present at our meeting, because we are, we recognized from the beginning that one of the, one of the… the reasons for convening this agenda was the mega-groups, the concern that they are looking more and more like hospitals, replacing hospitals, so we are here dealing with the interface and the interaction between private practice and institutional practice. And we will, I think, need some guidance, but to a significant degree, I don’t think it’s our job to work out the legal mechanics. It’s our job to decide what is right and then have the lawyers translate that into any necessary regulation or likely statue.

ART LEVIN: So, and this is not just phenomenon going on, I mean, in the Village, whether it's because St. Vincent's disappeared or whatever, these things are opening like, you know, a haircutting salon. There's one on every block now. Every time you turn around there's a store sign "coming."

JOHN RUGGE: Which is what I could contend is exactly the best reason why we need this discussion and we need some categorization and we're probably not going to get it perfect, but at least by having it, we can keep refining to get it better. And to shape the system that is otherwise going up based on incentives that exist that are going unmonitored.

CHRIS BOOTH: Incentives is one part of it; the other part of it is convenience. I think I said this last time, I think the real conflict here is between what's right for taking care of people's health versus convenience. And right now, the market is, is walking towards convenience.

JOHN RUGGE: And if it were to be patient-centered. We have a conflict of interest, do we not?

ART LEVIN: But that's not, I mean, that is a patient-centered issue and going back to crossing the quality chiasm, one of the things we said in there was people get sick 24/7/365,

and the system needs to be responsive to that reality and it never has—I mean, it never has worked towards that, so the market's wide open for people to say, "OK, I got it. I can be open on Saturday, Sunday until 11pm and have a place for your kids to play."

JOHN RUGGE: I think in response to that, if we really had a, according to a phrase, a fair and balanced health care system, a delivery system. [laughter] Sorry, wouldn't it include, and perhaps in one organization, indeed the mega-groups tend to have this, to have very convenient walk-in center for minor illness with a nurse practitioner looks at your sore throat, takes a throat swab, and nothing more needs to be done in that visit because you got your regular visits coming up anyway. And have your regular office visits where you do a comprehensive primary care for all your problems and the urgent care where you do run in often at inconvenient hours, often on weekends, and the rest, and certainly also, in that community an emergency department for that, for that terrible chest pain or the head trauma, or the near-amputation, or the actual amputation, all of that. And what you've got to do is get the right balance; to get the right balance, we've got to do the definitions and we don't even have definitions yet that are operative in our environment.

HOWARD BERLINER: John, aside from the primary care homes, I mean, what's our understanding of the level, the adequacy of primary care delivery just in individual physician offices? I mean, if you are going to say for one thing, you know, four visits then a primary care— what is a primary care visit then?

JOHN RUGGE: We don't know. I mean, up to now it has gone, it has been the dark side of the moon. It's been really unlooked at and I think it might be a bridge too far to say we're going to know all that or look all that, but I think a very open question is how confident are we that the patient medical home is so desirable or so evidence-proofed that we should give some sort of preferential referral. The urgent care center refers to a patient medical center, medical home it's a better thing in terms of reimbursement even. Or some preferred route. If you go to a PCMH, you get credit in some, in some fashion. Do we know enough yet? And what would it take to know enough? I don't know.

PETER ROBINSON: Well, I do think that we have to be sure that if we're going to deviate from where national policy—and CMS is pretty much defining that in terms of the way care is organized, delivered, and recognized—we ought to have some good reason to do it so that we actually don't create a more complex

administrative structure within our state. I mean, I think, I mean the default almost needs to be to line up, I think, as much as possible with CMS and certainly when it comes to things like being able to access medical information effectively, to communicate it effectively, to have patients have access to it. So I mean, when we are talking about things like urgent care, we need to look at how those entities, to the extent that they are going to be identified and some way sanctioned more formally, have to tie into the rest of the delivery system in some of, some way. So there's, there's a quid pro quo, if you will, for the, for that sanction and it's gotta be that they, they can't be completely disconnected from the rest of the system.

JOHN RUGGE: Just as a note, another thought following up, too, we've talked about upgraded D and T, but maybe what we really need to think about is, is there such a thing as upgraded primary care, as defined by the patient-centered medical home. Medicaid is already recognizing that and paying for it. Many commercial payers—on a pilot basis and on a regional basis—are doing exactly that, as well. And we may be approaching that break point where it becomes standard operating procedure rather than, rather than considered an experiment. Glenn.

GLENN MARTIN: Yeah, I was gonna, I wanted— I mean, we may end up, and we talked about it when Senator Gottfried was here

is, is, is regulating the term more than the practice. You can't call yourself, it's like Jeff's sign said back then is that psychotherapy up until a couple, a few years ago, anyone could call themselves a psychotherapist because New York State just didn't care; now it's within the scope of certain people can call themselves psychotherapists. The thing about urgent center, if you are going to call yourself urgent, there are standards you have to make otherwise you can't use the term "urgent." But the other point I was going to make. Convenience works both ways. It's also for the convenience of the practitioners. And that, I think, and convenience can be bought, which I think is what you were just alluding to. When my kids had a pediatrician, they were based out of LIJ, and when he went home at night, you know, it was basically you go to the urgi center. But the urgi center, with the same residents and the same people who you knew anyway, and they called it an urgi center—it was basically he didn't want to get his butt out of bed, so you would have somebody else take care of it, which was fine and it was continuity. But it's the same sort of thing that for a large OK, where patients can't get to their primary care doc, it's because their primary care doc isn't going to be reimbursed particularly well to work on the Saturday necessarily if they don't do it on a regular basis. And some of it is just a question of paying for it. Or it's subsumed under one of the other models you had— either a home— a home, your medical home may require it, or the

ACO may require it, or it just works out to be cheaper to pay more on that site than to come up with something else. And I think with we're seeing is because we don't provide that coverage anymore, and that's not the way that it's reimbursed or how physicians are thinking, you end up having the urgi center pop up to fill a need, but it's probably the best way to go. Again, my guess.

JOHN RUGGE: Wouldn't it be interesting to speculate, perhaps, in defining that high-performing primary care practice, include an affiliation with an urgent care center. That urgent care could be internal—it could be something sponsored by that group or that physician himself or herself, or it could be a service and part of that would be the availability of medical information on an assured basis. So when the patient goes in the urgent care they can access that patient's, that patient's records.

PETER ROBINSON: So, you know we have, this is a sort of a health planning issue, right. So, you have primary care practices that have existing infrastructure. Some may have access to radiology and other ancillaries, others may not. And those facilities—they are not offering after-hours care—are actually, have a lot of stand-by capability that just shut off, for periods of time when people, predominantly, want to access

urgent care, right, which is after hours. I mean, the peak for urgent care, similar to the peak for emergency room activities, where you start to peak in the evenings and you kind of come down again and then it just moves up. I wonder whether there shouldn't be incentives structured so that primary care practices pool their physical capabilities and either rotate or one of the sites actually becomes an urgent care which they collectively cover. I mean, there are ways to get at that capability without adding costs and, and expense to the system.

JOHN RUGGE: It strikes me that could be a natural second-stage to this rocket; I am not sure we are ready to mandate anything like that, but if we can, we can set the terms right, that will help. We can help that to evolve in exactly that kind of fashion.

PETER ROBINSON: But it's actually where I was getting to with what we incent. That's, that's a little bit, an example of that.

JOHN RUGGE: Just speaking very personally, in our, in our centers, we groom our centers, we found that we had to begin to dedicate more open time and eventually we dedicated, dedicated space and people, totally on book, so that capacity was there and I think it's a natural phenomenon of growth,

private practices are doing the same, and now the open question for us, is it time for us to recognize that in some formal way, put a label on it, understand what it is, and have more standardization than is available currently. That is the open question.

HOWARD BERLINER: It seems to me that one of the things that we now have the technological capacity to do that we haven't had necessarily in the past is the ability to have everyone, all medical providers independent of how we classify them, have access to medical records. And it seems to me that if you had an urgent care center, which is only providing very, you know, rudimentary kind of care for certain things, I mean at least if they had access to a record, someone could make decision as to whether, you know what, you've got other problems, I can't see you, or, or include it in the record so it then goes back to someone who's maintaining that.

JOHN RUGGE: You know, equally important, I think, Howard, is knowing what the allergies are and what other medicines you are on so you are not having an interaction that would otherwise would be unexpected. You are going to change the BLOOD LEVEL of your Coumadin because now I am putting you on ETHELFA.

Exactly. Exactly.

MS. CLEARY: I could just add there was a lot of lessons learned from the retail clinics, some of which we teased out and are going to apply across the spectrum or offer to the Committee to apply across the spectrum. They get it, what Mr. Robinson was saying and yourself, there's a lot surrounding HIT that they are going to be requirements about in inter--- systems, sharing of information, connecting to the SHIN-NY, to the RHIO, et cetera, and that would apply to both the retail clinics (who we call limited-service clinics), freestanding EDs, and urgent care.

JOHN RUGGE: Back to our introductory. Oh. Sorry.

[inaudible]

JOHN RUGGE: Yeah, I just want to make sure. This is our one good opportunity to make sure there's no additions or subtractions or changes we should do.

JO BOUFFORD: I liked it very much, as well. I just, the only thing I didn't, that didn't jump out at me, but I think it's a principle we've been espousing is these, the inappropriate use of emergency rooms, that somehow, I was thinking maybe it fits in the sort of, at the end of the triple

aim section where it talks about ONE ADDITIONAL'S continuity that I think maybe you could insert it in that paragraph. Because I think there's something, that's something we've been talking about all along, so…

ART LEVIN: Which… which triggers in my mind the thought that emergency rooms are not necessarily the best places to get care. I mean, there are a lot of issues around the safety and quality of care that you get at EDs and you're actually putting yourself at risk, perhaps unnecessarily, in an emergency room setting that you wouldn't in some other setting and we won't SAY which one, Ellen.

ELLEN RAUTENBERG: I've got a small number of just edits, but I would put under 2.2 a whole another bullet that involved care in the home and in the community and I would probably use asthma as the example of, of high-performing primary care, which I didn't really see there, which I think is, would be a good thing. And I guess I just wanted to, just one other— I mean, obviously…

JOHN RUGGE: Did you have a chance to do a look, to write a paragraph.

ELLEN RAUTENBERG: No, that’s what I mean, a whole another bullet.

JOHN RUGGE: No, that’s what I am saying. You. [laughter]

ELLEN RAUTENBERG: Well, why don’t we refer back to the author? Can’t he…

JOHN RUGGE: Well, we can, but if you could just give a… give a… give a bullet in terms of what you mean and we’ll send that…

ELLEN RAUTENBERG: Right, like doing public health in your primary care setting, you know.

JOHN RUGGE: Take a stab at it.

ELLEN RAUTENBERG: OK. OK.

All right.

Try to too many

I guess, I just in terms of the question of leveling the playing field, and I guess I almost have this in the last meeting also, I’m not sure what our role is in fair competition, leveling the playing field. It’s not just in this committee, but it’s in the previous committee, the establishment committee, and

it might be worth a whole conversation with the Committee about that as a function— as our function.

JOHN RUGGE: You were saying basically to elaborate again. There's a two-part thing you are basically saying where there— where there is really competition, we have to make sure it's fair, which is a little different than saying a level playing field. And in recognizing in some areas there's a dearth of providers or a dearth of population, or a special population, we're really talking in my mind about a utility model rather than a competitive model. And that, this speaks to the diversity of New York. Other… other…?

ELLEN RAUTENBERG: I see when things start getting contentious in establishment, a lot of times it's around these issues.
I just am, I am sort of unclear about the role of PHHPC.

JOHN RUGGE: We are constantly touching that third rail, because we are talking about the intersection of private practice, propriety ownership, not-for-profit, and regulated article 28. Absolutely. Neil Benjamin volunteered a couple of items, too. One is he thought it might be good to have a section or a paragraph explicating a bit more about the MRT and how the MRT reforms play into everything we are doing. That makes sense

to people? And he, of all people, rather than anybody at this table, said it really doesn't reference FQHCs as part of the landscape and I think in any description of the landscape, at least a mention that FQHCs would be helpful. Anything more by way of…

ART LEVIN: Just to elaborate on Ellen's point, it's really we're missing the patient engagement part or the shared decision making part, or any of that if we take it seriously as being integral. You know, these are not the places where those conversations take place, you know, so it's really.

JOHN RUGGE: Good. Good. Very important. Does every… otherwise, do we buy it? I mean, continuity of care. We have not talked about continuity of care. That's his addition. And I think a very helpful way of doing a shorthand understanding of what we are talking about in terms of primary care, what we're seeking. I'm hearing no dissent. We have a night to sleep about it, so maybe first thing tomorrow, if anybody has any new thoughts, having had this conversation we can come back to this very briefly, I think we'll have a very robust conversation and set of interactions tomorrow, some urgent care providers, find out what they are what they are doing.

[Ten o'clock?]

JOHN RUGGE: Ten o’clock. Here. Thanks. Good. Good. I think that’s really good. I think this also… yeah, and I think that helps to digest it.

[end of audio]