WILLIAM STRECK: Good morning everyone. I'm Dr. William Streck, the Chair of the Public Health and Health Planning Council and I welcome you to the meeting today. Dr. Zucker will be joining us a bit later. He's in a conversation with the Governor at the moment, and will join us and provide his initial report to the council at that time.

I'd like to remind the 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 the on demand webcast will be available no later than seven days after the meeting for a minimum of 30 days and then a copy will be retained in the Department for four months. I'm not sure anyone has ever pursued that avenue of information gathering, but it's there.

We do have some basic ground rules which I will reemphasize; there is synchronized captioning so it's important that people do not talk over one another. The first time you speak, please state your name and briefly identify yourself as a council member or Department of Health staff. The microphones are hot to side conversations can be picked up and rustling of papers can be disconcerting. As a reminder for the audience there is form that needs to be filled out before you enter the meeting room which records your attendance at the meeting, and it is required by the joint commission on public ethics in accordance with executive law section 166.

So, with that, I'd like to begin today's meeting. As I mentioned, Dr. Zucker will be joining us. We will have under health policy, Dr. Rugge will present a request for a stroke center designation for Catskill Medical Center and present for vote advanced medical imaging and radiation therapy recommendations. We will then go back to the Department of Health reports. We'll have updates from the office of primary care and health systems management from the office of health insurance program activities and from the office of public health. Under the public health services category, Dr. Boufford will give an update on the initiatives of the Committee on Public Health and under the regulation group, Dr. Palmer will present three regulations for adoption. We will then move to the project review recommendations and establishment actions and this will be led by Mr. Booth serving as the vice-chair of that committee in the absence of Mr. Kraut. I would remind the group that if you have conflicts, this is for council members, please make sure that these have been recorded with the staff so that we do not have to pursue this afterwards. So with that I would move for adoption of the minutes of April 10, 2014. May I have a motion? So moved. Second? Seconded. Discussion? Hearing non, those in favor Aye?

[Aye]

Opposed? Thank you. The minutes are adopted. So, while we wait, Dr. Zucker will move to the health policy report and I'll turn the chairmanship over to Dr. Rugge.

JOHN RUGGE: Thank you. As everybody probably remembers the planning committee undertook a review of ambulatory care services some time ago. The report is very much in the making. Legislative proposals were submitted to the legislature, but one issue that we did not complete until now has been review of advanced medical imaging and radiation therapy services. This is in the context of recognizing we really have two playing fields; one on the institutional side, one for private practice, and some concerns regarding potential overutilization of advanced medical imaging and perhaps some inappropriate utilization of modalities of radiation therapy. That concerns overuse. So, in that context we approach a somewhat more thorny set of issues than we anticipated, but had amazing help from staff, and I guess Alex, are you going to lead us through the considerations that we wrestled with and then a series of recommendations we have for the Council.

ALEX DAMIANI: Good morning, and thank you. So, I would like to just summarize the recommendations but the first few slides that we will go through will review just a little bit of

the background material very briefly. Now, do I have the clicker for the slides?

OK. All right. If we could go to the next slide then. For starters we'll take up these two topics of advanced medical imaging and radiation therapy. We'll start with the advanced medical imaging, if we could have the next slide.

Three real issues to be addressed in this topic were ad Dr. Rugge mentioned the issue of utilization or overutilization, quality and patient safety that is typically for my program area that has been our focus, imaging key way, and –

OK. Sorry. And the issue of cost. So those three items of utilization, quality and patient safety, and cost. Any discussion of advanced imaging or imaging in general we do have to mention the restriction on physician self-referral here and that is the STARK law. So the STARK law really prohibits, for instance, a radiologist from being the doctor you go to and say, I want a CT. You have to go to your primary. He'll refer you out to the radiologist. There is an in-office ancillary service exception that will allow primary care or any physician for that matter, any licensed physician for own and operate advanced medical imaging equipment. Good. The next slide.

Two other points of law that are important to note; there was the MIPPA or Medicare Improvement of Patient and Providers Act, and the important point here is that this started to require accreditation. This is a federal law and this was

implemented in 2008. A second slightly earlier provision was the Deficit Reduction Act of 2005 and the real important point here is that it caps the technical component. In the imaging world there's two components; a technical and a physician. So providing the service you get the technical, the physician doing the interpretation received the physician component. OK, if we go to the next.

Now, those were some statutory issues, just in term of the current regulatory environment in New York State. In New York, all radiation producing equipment is registered. OK. All radiation producing equipment in the medical world is inspected, and those inspections vary depending on what you're doing, but they're typically one to four years; one for a mammography and four years for something like bone density, (DEXA) scan. Now, we did have a question last time, just a brief aside, a question about backlog of our inspections. We're doing about 1400 inspections a year of medical equipment. We had absorbed some commercial equipment from the labor program several years ago. They did not inspect that equipment. They just registered it. So we have that equipment that we are trying to work into our inspection process. It's not a regulatory requirement at this point that it be inspected, however, so. With respect to diagnostic nuclear medicine that's handled a little differently. Radioactive materials are actually regulated at a federal level and the states have to adopt those rules and New York has. And

so the inspections are specified a little different. But there are three to five year frequency for most types of nuclear medicine. So, somebody from the Health Department is going out to every site that's using some type of imaging equipment at those frequencies. And just as a note, MRI and ultrasound are not inspective. They're not registered or licensed by the State. And an important point with respect to those three topics we mentioned, our inspections and our registration at this point in time really focus on quality assurance and radiation safety. They do not review need assessment or any clinical practice issues.

Next slide please.

CHRIS DELKER: Just to review the current CON requirements for article 28 facilities operating CTs or MRIs, for hospitals or any extension clinics thereof, they're subject to just limited review focused on architectural and engineering safety issues. For D&TCs or any other non-hospital provider they are subject to administrative CON review. OK. Next slide. And there is no CON review for MRIs or CTs operated by private physician offices. As you know, we don't have jurisdiction over private practice.

OK. Well, this just gives you an idea of other states and what they look at. As you can see we're not the only ones who

have varying degrees of review over imaging services ranging from pets to MRIs to CTs and so on.

ALEX DAMIANI: OK. Now if we can actually proceed into the recommendations. These were based on several meetings and really culminated in a meeting three weeks ago, May 21, but I think the first point we want to include here is the uniform definition, what are we talking about. Really do want to clarify what are we talking about in advanced medical imaging. To that intent, adoption of a definition similar to the MIPPA may be modified as needed, but keeping in that context would probably keep the field as sane and clear as possible. If we go to the next slide we actually see what that definition is and what it is and what it is not. It's very clear in that it includes these three big ticket items, if you will -- MR, CT, nuclear medicine -- and it excludes your standard – Xray, radiography as it's referred, fluoroscopy, ultrasound. Those three clearly off the table. OK. All right. Next slide please.

Next point, next recommendation would be the requirement for recommendation and again this would be for all providers regardless of the ownership, article 28 or private practice, and this would require a third party accreditation by a national accrediting body as approved by the Department, with a provision that if a provider physician or hospital loses their

accreditation they must report to the Department. Next slide please.

The next topic or the next recommendation was that the Department should work with provider associations whether it's MSNY, State (RAD) society, other physician organizations within the State or at the national level to provide outreach and education to practitioners who are prescribing CT scans or other imaging studies as determined by the Department. And also that the Department should promote a public education campaign on the benefit and risks of advanced medical imaging. Now, there are some very well-received education campaigns that are developed or have been developed by a conglomerate of four groups; the Society for Pediatric Radiology, the American Association of Physicists in Medicine, the American Association of Radiologic Technologists and the ACR as well—American College of Radiology. And this is broadly known as the 'image gently campaign' and it has a physician education component and a patient education component.

All right. If we can have the next – thank you. You're ahead of me here. The next recommendation was that we would include some form of documentation of the total number of CT scans in the patient chart. Now, the discussion had originally focused on cumulative radiation dose being monitors, and there are technical difficulties right now with that. California attempted to implement this two years ago. It was a disaster

and they had to actually change the law significantly because it's just technically not a feasible thing right now. That would be an ultimate goal, and manufacturers and the physicists are working on being able to do that, but we're still a few years away from that point. So if we could have the next slide, and I'll speak for Chris here. Really just retaining the current CON requirements for the article 28 providers.

CHRIS DELKER: And just to go back to, we don't have to go back to the slide, but just to, back to the numbers of article 28 facilities, we looked at three years of data for CON applications for MRIs and CT scans, CT scanners in 2011, 2012 and 2013, in each year there were a dozen applications, limited review applications or in the case of two of them, D&T center applications, so it's not of late the high volume activity. So, a dozen a year CT, MRI applications total, and only two of those out of those 35 or 36 were for D&Ts. The rest were for hospitals or their extension sites.

ALEX DAMIANI: All right. And our final recommendation here then would be to require an expanded registration with a data submission for all providers, article 28 and private physician offices that have advanced medical imaging or that purchase new equipment. And the data requirement would include the provider location, type of the practice, the practice size,

the services, the payer mix. This data should be collected, will be collected by one point of contact in the Department, and no more than three years after this expanded registration or enhanced registration has begun the data will be analyzed to evaluate if any further action is indicated.

Now, with respect to the next slide, with respect to the regulatory requirements, what has to be changed in our regs here, for starters we again would want to adopt that definition. So we would amend part 16 to include the definition of advanced medical imaging. We would, the second point, revise part 16 to require all advanced medical imaging providers to obtain accreditation by an approved accrediting organization – and the third point would be that we would revise the part 16 regulations to require all these providers including again, article 28 providers and private physician offices to submit that expanded registration data to the Department. And now if we turn to Dr. Rugge, if we would like to open the floor for discussion.

JOHN RUGGE: Simply note that we talked about the big issues of restructuring of ambulatory care. I think the committee have kind of a Eureka! moment in realizing there is a way to reconceive the various modes of ambulatory care with primary care being the base foundation, minute clinics or retail clinics going to urgent care, going to freestanding ED, going to

on-campus ED representing a spectrum of episodic care which should relate back to primary care, and there was a flow. In this case we had a slog, so slog through the details of one more narrow component, albeit a very important component of ambulatory care. Took three meetings and found ourselves stumbling over inability to get data. For example, it seemed intuitive that we should look for a record, an ongoing record of the cumulative dosage of radiation, a person received in the course of a lifetime to guide future care. We found we couldn't get that because the manufacturer that actually can't easily record from machine to machine the various doses. So we had a fallback position. So let's count the number of, the number of CT procedures emitting this kind of radiation and found well, we can't even do that in a meaningful yet, way yet, but at least we came to recognize there's a need and are proposing that we look for the technology, seek the technology to allow us the next sequence of committee reviews three years from now to achieve those goals. So, again, I think the overall, this represents a felt need for more information from (nor gathering) and preparation for a broader change to come in the next generation. I'm sure there's some comment. Mr. Robinson.

PETER ROBINSON: Yeah, I share your frustration Dr. Rugge, with the, both the nature of the deliberations that we had to go through and think that the recommendations actually

fall far short of where we ought to be moving on a couple levels. First of all, the general sense of getting a level playing field is still not here with what we've done. We've moved a step closer, I think, but it really isn't the case. But I do actually think that both of these technologies, this one and the one we're going to discuss next, are really right for overutilization. I think we all can agree that in many marketplaces competition will actually create lower cost, more efficient utilization, presumably more consumer benefit. I don't believe that healthcare generally does that despite all of our efforts to allow the competitive marketplace to work, and I do think that we are now creating a situation where we have tighter regulations still over article 28 providers who are somewhat more hamstrung than those in private practice. But I also think from a consumer standpoint with all of the efforts to begin to utilize services more efficiently and more thoughtfully that we're still going to allow for a proliferation of these technologies, and without any rational. And it seems to me that the term "certificate of need" actually never gets to that last word and we never actually look at what the real need it as opposed to allowing the marketplace to determine it. And I'll come back to my conclusion that the marketplace doesn't work. So, I'm expressing my frustration with lack of progress on trying to bring these regulations to the point where the playing field is leveled, and frankly that there's no need methodology

for either one of these technologies. So I will support this as a step forward, but I am very concerned about the fact that the next steps are fairly vaguely prescribed here. There is no clear stop. It's just we're going to look and analyze it again, and I think that's inadequate. So, thank you.

JOHN RUGGE: Howard.

MICHAEL FASSLER: Just a couple comments. First, again, I agree with Mr. Robinson on this, we don't have a level playing field if you're talking about getting, we have to work towards that, then one particular area, because I won't go on that issue, but one particular area here talks about we have a limited review for CT and MRIs for article 28s, and it's only folks in architectural. Why do we need to maintain that? Department's limited resources, why are you focusing on architectural review in that area?

CHRIS DELKER: I think we will shortly be going away from that, so in fact, it would be a notification from general hospitals. They would still have to submit you know, any architectural or engineering specifications bearing on safety shielding that sort of thing, protection, but back to one of the points made earlier about no need methodology. There is a need

methodology for MRIs. It is applied only for non-hospital applicants such as D&T centers.

JOHN RUGGE: Dr. Berliner.

HOWARD BERLINER: Tom, who's expected to be the single point of contact in the Department? Is it your group? The single point of contact?

TOM: I'm sorry?

HOWARD BERLINER: Is the single point of contact that reports come into, is that going to be your group or is that –

TOM: I don't think we've determined that, but that would probably be a reasonable –

HOWARD BERLINER: And so, Commissioner's not here yet – are you staffed up enough to handle the additional, all that additional data and new responsibility or would you need more staff to do it adequately?

ALEX DAMIANI: In terms of just taking the data I think at this point we can do that. Analyzing it is another story. But, just, you know, being that point of contact and then sharing

that with whoever's going to do the analysis within the Department, that I think we can handle.

JOHN RUGGE: Dr. Martin, did you have –

[Sorry, I didn't hear the answer.]

ALEX DAMIANI: I apologize. The – in terms of who can accept the data I think we would be probably the most reasonable point of contact, since we're already collecting part of the registration data to just add to what we're collecting would be something we would be capable of doing. In terms of analyzing the data, I don't think my unit at this point in time could do that.

JOHN RUGGE: Other questions – Dr. Brown.

LAWRENCE BROWN: This is Dr. Lawrence Brown. I'm sort of curious, it seems like, and based on your last response that this is not going to be a trivial undertaking. So can you share with us any general ballpark of cost estimate of what it will take to actually implement this assuming that it is approved and probably when the commissioner comes here we can find out where we expect to get those resources from in order to accommodate that. So do you have any information about general ballpark

about what additional resources in terms of dollars and cents will be need to implement this?

ALEX DAMIANI: OK. As John just reminded me, actually, we do not necessarily in my unit that is composed of physicists that do the inspections and registration for this equipment, we don't have the staff to do the analysis. There are other programs in the Department that would be able to do that. So the structure is there. I did not want to commit to that only because that's not something my program can. So it does, we do have the ability to do that analysis at this point without the request for additional staffing or resources.

JOHN RUGGE: Dr. Brown.

LAWRENCE BROWN: Can you help us to understand by providing more clarity about the private physicians' offices that you were talking about? Are we talking about group practices? Are we talking about single physician practices? Do you have a sense of that?

ALEX DAMIANI: Well, right now in terms of just the total number of facilities that are registered, I have that. That's roughly 11,000 in New York State. Total number of medical facilities excluding dentist, the biggest dental is the, --

7,000 of those are dental, there's probably in the order of 2800 to 3000 medical facilities. Now, that's everything. That's hospital, that's a doc with just a chest x-ray unit. CTs, we're talking about 450 facilities in upstate New York. I'm not sure what the number is in New York City. New York City Department of Health registers equipment in New York City. My guess is that it's, assuming the percentages usually hold similar between the upstate and the downstate, knowing that they have about 7000, my guess is that we'd probably be looking at total registrations, my guess is we'd probably be looking at 300 to 3350 facilities in New York City that have CT. MRI, I have to confess, we don't have a good handle on that. We can certainly go to Chris's group and find out – article 28 facilities – but do not have a good handle on the private practice facilities.

If I could, just one other thing, I apologize. We already do collect a fair bit of data in our registration process. So this is really just adding a few elements to that form. The structure is already there. It's modifying the form and collecting some extra elements.

JOHN RUGGE: By way of procedure, may be best to move this particular set of recommendations, acknowledging that there's more to get done, but this is as far as the committee

felt it was reasonable to go at this time given the state of information. So, I would – Mr. Robinson.

PETER ROBINSON: Just because I don't want to have to chase a motion after it's made, could we in making the motion on these recommendations where there is this three year timeline for analyzing it, I'd like to actually have a concrete return to the council for a revised or updated set of recommendations, something that's definitive where there's an action point following that review, because the review is sort of an open ended, and we'll look at it, and I'd actually like the Department to come back at the end of the review period with a series of findings and recommendations for the council to consider.

JOHN RUGGE: Would you like to propose it?

PETER ROBINSON: If somehow you can turn that into a motion that people can vote on, then I would move that.

JOHN RUGGE: Let's do this; let me move the recommendations as they stand and then look to accept any amendments that may come from the floor that being the first, and we can vote on the proposed amendments. So, there's a motion

on the floor. I don't believe it needs a second coming from a committee chair.

WILLIAM STRECK: No, it does.]

JOHN RUGGE: It does. Second. Moved and seconded. Now we'll look to any revisions or amendments. Mr. Robinson, you have a proposal.

WILLIAM STRECK: Well, actually now it's before the full council so I'll – then I have to finish this part of it. OK. So now we have a committee make a recommendation. It has been seconded. Now is before the full council for further discussion or amendments. Are there any proposed amendments?

PETER ROBINSON: Has my amendment been included? Or do I need to resubmit it?

WILLIAM STRECK: We'll consider that a resubmission. OK. Thank you. So that amendment, one week, plus or minus D-day and three years there would be a report from the Department on this. Is there other discussion on the proposal? Dr. Martin.

GLENN MARTIN: Just a point of clarification. I mean, I – the analysis would be of the new information that we're asking

which is limited to about six different things? From what I see I'm a little confused about what the analysis is – I mean, I realize it could be a full analysis of how we're going to modify going forward. I guess what I'm asking is that is the raw data here seems to me should be available to the committee during interim steps if requested.

PETER ROBINSON: That would be great. Yeah. Actually what I'm looking at here is we've gone essentially to accreditation and reporting for private practice as opposed to full CON. And what I'm looking to do is see that at that date certain we determine if that has been sufficient to manage that particular modality or whether we need to relook at that again.

WILLIAM STRECK: So, the initial data collection is essentially demographic data about practice sites and scope. It's really what is outlined there.

GLENN MARTIN: If I may. As I understand it's provider location, type of practice, practice size, services, and payer mix. So I'm just asking is that if people are going to register within six months or a year, whatever the reg is, is I assume that data could be made available without incredible statistical machinations that we can at least get a count relatively soon.

And if that's understood then I don't have to make another amendment and that's fine.

WILLIAM STRECK: OK.

GLENN MARTIN: Head nodding. Great. Thank you.

WILLIAM STRECK: Other comments, questions, suggestions? Discussion? Dr. Brown.

LAWRENCE BROWN: I must confess that, first of all, I want to commend the Department and the committee for what is clearly a lot of great work and bringing it to this point. I guess the, my level of concern is the issue about just counting. Counting, and I do understand the technological difficulties with the reason why we're going with this approach, but just counting something does cost resources. Counting without some kind of, like colleague Dr. Martin says, machinations, seems to me a bit unfulfilling. It's like saying that we have a menu, yet you can't eat at the table. I'm not sure that there's anything that we can include that actually allows us to evaluate rather than – because the accreditation having docs and private offices go through accreditation when they currently do not have, there's clearly a cost. So I'm not sure if we want to take that into consideration because that cost has to go

somewhere. It's not going into the stratosphere. So, it seems to me that something that allows some level of evaluation would make this to me even more useful. Even in light of my colleagues, Mr. Robinson's comments about the, his concern about it, having no evaluation other than counting seems to me that we can do better.

ALEX DAMIANI: If I may, just address the one point of the cost to the providers for accreditation. At this point in time most non-hospital based providers as of 2012 if they're receiving any payments from CMS for CT or MR must have complied with the accreditation requirements in the MIPPA which more or less means you're either accredited by ACR, (JACO) I apologize, Joint Commission, Intersocietal Accreditation which does primary head and neck CTs and just I the past few months there's a fourth body that health and human services has approved, but I'm not sure if they have taken any customers yet.

WILLIAM STRECK: Additional comments? Questions? Hearing none, those in favor of the recommendations as presented please signify by saying 'aye.'

[Aye]

Those opposed, nay? So this series of recommendations has been accepted by the council. Move to the second series. Thank you.

JOHN RUGGE: Alex, we'll give the floor to you.

ALEX DAMIANI: Thank you. OK. Our second topic up for discussion here is radiation therapy. We can go to the next slide. What we're including here in radiation therapy really consists of two primary activities; one is external beam therapy—that is the more prevalent therapy modality—but we're also including brachytherapy and that is typically the insertion of a source into either a body cavity or the most common type is prostate seed implants where small sources are placed around the prostate to deliver a dose of radiation. Within the external beam category the two terms you're going to run into a lot, image guided radiation therapy and image intensity modulated radiation therapy, and these are just two methods of delivering this external beam radiation. And just as an important note, we do say of the three typical treatment methods between surgery, chemo and radiation, that approximately half of the patients will receive radiation therapy in some form, cancer patients. If we could go to the next slide. Again, with respect to some of the issues to be addressed here, we were really looking at those same three we looked at for advanced imaging; access, or

utilization, quality and patient safety and cost, but we also included access in here as well. Some of that really just went within maybe not as much in the New York City and the metro area but in some upstate areas access gets to be a little bit more of an issue than the imaging world.

All right. In terms of the federal oversight and New York State oversight, with respect to the use of radioactive materials in therapy, that is regulated by the Atomic Energy Act of 1954 which is governed by the NRC at this point. The NRC requires the State to comply with that standard. We are an agreement state. We follow their structure. So, radioactive materials get licensed. Linear accelerators are registered, x-ray producing equipment and so they're subject to somewhat different regulatory mechanism. But in both cases they are regulated by New York State, by the Health Department at the state level, or at the city level. And just another important point as we discussed MIPPA, radiation therapy is exempt from MIPPA. All right. And the most recent amendment to part 16, enhanced are quality assurance requirements and at this point in time we require accreditation by either ACR or by ACRA. That requirement becomes final in November of this year. Next slide please.

So, as I mentioned, all providers that use radioactive materials do have to comply with this NRC standard which we implement, and just as a way of comparison, when you look at

other large states – Texas, Florida, California, Pennsylvania, Massachusetts – states with comparable size populations and geographic distributions to New York, we find that they have fairly similar mechanism in place.

All right. We can go to our current regulatory environment. Now that was more the statutory end of things. the current regulatory environment here, very similar to the imaging world. All the equipment is registered. All the radioactive materials are licensed by either New York State or New York City Department of Health. Therapy equipment is typically inspected every two years for linear accelerators. Materials based programs again may vary a little, but given that the majority of the equipment is two years, its reflected that on the slide. Also important point to note that with respect to the inspections and the registrations, these are focused on the quality assurance on radiation safety. Again, we're not assessing need, clinical practice, appropriateness, any of that. OK.

What do we require with respect to accreditation? Part 16 requirement that went into effect in May of last year gave providers 18 months to become accredited by either ACR or ACRO. So, through the accreditation process they do review some of the clinical uses and the appropriateness issues. The ACR and ACRO both have established practice guidelines for radiation therapy practices that deal with physician training and treatments. And

so the use of these guidelines will assist in addressing the concern about appropriateness of certain types of radiation therapy, things such as IMRT that have some review in the literature would indicate there is some overutilization of IMRT in certain cases where it may have questionable benefits. We go to the next slide please.

CHRIS DELKER: Full CON review is required for article 28 entities being certified for linear accelerators for radiation therapy. There is a need methodology. It's based principally on incidents of cancer in the service area with an assumption about a certain percentage of those cases being amenable to radiation therapy and within that certain number of those cases, a certain proportion of those cases being suitable for palliative care and the other for curative care. Again, just as with any other private practice, CON does not extend to the use of RT by private physician offices.

ALEX DAMIANI: And just as a point of note here, these recommendations are not to apply to the proton beam therapy demonstration project. That is covered under a separate set of regulations.

So the first accreditation really is a modification to the accreditation process and that is to amend that to require the provider either an article 28 provider or a private doctor, if

they lose their accreditation to have them report to the Department of Health.

The next slide then. Sorry.

CHRIS DELKER: I think it was the sentiment of the committee to retain the current CON requirements for radiation therapy for article 28 providers and certainly the Department concurs with that.

ALEX DAMIANI: Ok. And the last recommendation here is to expand the registration in a manner similar to the advanced imaging, to require the submission of data including provider location, type of practice, practice size, services and payer mix. To require that this data, again, be collected by a single point presumably that would be my office and have the analysis conducted by another part of the Department. And then no more than three years after that registration to evaluate what further actions should be pursued.

Now in terms of pursuing these recommendations we would need to make some regulatory changes, again, to amend part 16 to require that the providers report if they fail the accreditation, and as a second point, to amend part 16 to require all providers article 28 and private physicians, to submit expanded registration data to the Department.

Thank you.

JOHN RUGGE: Mr. Robinson.

PETER ROBINSON: OK. On this one we have a need methodology and so it seems to me incomprehensible that we wouldn't apply that need methodology across the state as opposed to doing it for only one segment of the population. And I am not sure that losing accreditation and just reporting it does anything. So we know what happens, and it doesn't seem to me there's much going on other than reporting it, so I actually will be proposing an amendment to the recommendations here. One, that these article 28 requirements apply across the board and secondly that loss of accreditation should at least result in suspension of a provider's ability to operate their facility until such time as those accreditation issues are addressed.

JOHN RUGGE: By way of local color, the committee did have an extended discussion about removing the – I'm sorry – with regard to need, about having available to the council all information regarding private practice, radiation therapy, as well as institutional private therapy for consideration, only to realize that in doing so we could preclude any expansion by any hospital or institutional provider of it's radiation therapy service, and that seemed equally absurd, and so we dropped back

to this very conservative incremental approach. Further comments?

ALEX DAMIANI: If I might add just with respect to if a provider fails accreditation, if they don't comply with the regulations we can already pursue either suspending or revoking the registration. We do have that mechanism in place.

PETER ROBINSON: OK. I think it just needed to be then clearer in there. It just seemed to be that the reporting was the end of it, and you're suggesting that more follows.

ALEX DAMIANI: Yeah, if that is a requirement in the regulation and you fail to comply with it, then we go through an administrative tribunal process and we'll suspend or revoke your registration for failure to comply.

PETER ROBINSON: Well, I mean, I think that maybe at least updating the report so that we're aware of that. Thank you.

JOHN RUGGE: And again, are you speaking to Mr. Robinson's point, Dr. Martin? Or – Let me just point out I would presume that if we're extending need methodology to all providers we are in effect extending CON to private

practitioners. By way of further implications, I think this would require statutory action, legislative action.

CHRIS DELKER: Yes, it would require statutory change.

JOHN RUGGE: So, just as a point of information, this would be recommendation to the legislature, not simply to the Commissioner.

PETER ROBINSON: Well, I assume it would be the Commissioner that would bring that proposal forward to the legislature if he concurs with our recommendations.

JOHN RUGGE: Dr. Martin.

GLENN MARTIN: So, just in a similar vein, as it stands now if these recommendations were accepted, adopted, yada, yada – we'd still be in the same situation that we were when we reviewed the Certificate of Need for a hospital in Westchester that the Certificate of Need review of the hospital would not include by either statute or regulation any consideration of what the environment was outside of article 28s?

CHRIS DELKER: Right. If that's an article 28 applicant, we would only review those devices that were operated by other article 28 operators.

GLENN MARTIN: And once again, that would require a statutory change? Or is that regulatory if – one half is looked at rationally.

CHRIS DELKER: To extend CON to private practice would require statutory change, as my understanding.

GLENN MARTIN: But if we were to modify the C – assuming we only looked at one half of the playing field, could we look at that one half rationally by changing the regs, or would that require a statutory change?

CHRIS DELKER: If you mean that one half being the article 28 providers?

GLENN MARTIN: The article 28 by being able to take into consideration what the RT distribution was outside of the article 28s, (which we weren't able to do.)

CHRIS DELKER: The difficultly with that is getting the information. If there's no – if the private practices are not

covered by article 28, there's no burden on them to report, nor do we have authority to demand that information. That's the problem with that. Now, there were some reviews of radiation and other imaging devices done by the Finger Lakes HSA several years ago. I don't know if they've updated that, but that's the closest thing we have because that was able to take into account the private practitioners.

GLENN MARTIN: Can I follow up?

[sure]

So, I guess now I'm totally confused. If these regulations – if this is adopted then everyone will at least be registered. We will know who is out there, correct? And then if we know who is out there, I guess I'm asking if we continue to look at CONs for article 28, would that information now be plugged into the Department's recommendation of need based on this new knowledge of the accredited RT facilities in a geographic area.

CHRIS DELKER: We could amend the regulations to take that into account, the need methodology. Again, though, the problem, I'm not sure how far the registration would extend to reporting volume because part of the need methodology, it's not only based on cancer incidents and palliative curative mix, it's based on

as assumed optimum volume of procedures, treatments per device, and I don't know how assiduous or rigorous the private practices would be in reporting that information without some very pretty strict reporting requirements.

GLEN MARTIN: I'm just –

PETER ROBINSON: So you got half the system then essentially being managed on the basis of a 50 percent need methodology and the other half essentially without any restrictions on establishing capacity and driving utilization, and that's kind of where we would be once this thing goes through.

CHRIS DELKER: I think with regard to linear accelerators the 50 percent is – it's my impression that there aren't that many private practices operating LINACs yet.

PETER ROBINSON: I would agree that I don't know what that percentage is.

CHRIS DELKER: Yeah, we don't either.

PETER ROBINSON: But some fraction.

CHRIS DELKER: Right.

JO BOUFFORD: Yeah, I had a question in looking at the third party accreditation bodies. It mentioned the term "quality assurance" and I'm wondering, could you clarify what's included? You imply med – protocols which I think gets to some of the issues that Glenn was raising, clinical protocols, but is that quality assurance data made available as part of this? is there anybody looking at that or is it just accepting the third parties validation?

ALEX DAMIANI: Well, the quality assurance is really on the delivery of the dose to the patient. So, radiation oncologists will write a prescription and say let's deliver 8000 rads to this tumor volume, and the quality assurance goes into looking at the accuracy of this machine in delivering that dose, the accuracy of the treatment team in setting the patient up and ensuring that the correct parts are being irradiated. So a lot of it is focused on the delivery of the dose. That is the primary quality assurance that we're reviewing.

JOHN RUGGE: Dr. Boufford.

JO BOUFFORD: It, this, slide 28 – so this term, the use of evidence-based practice guidelines is basically just what you

said, it's nothing beyond that? Like, are they using it appropriately in the first instance, or any patient outcome information, nothing like that.

ALEX DAMIANI: In terms of the accreditation they will look at the qualifications of the physicians, so you're looking for radiation oncologists. They are looking for mostly safety and dose delivery elements and some continuing ed requirements, those sorts of things. In terms of appropriateness of the treatments, there is some latitude given in the physician review, where they look at things, are for instance, are you delivering, as an example that I had seen, are you delivering prostate treatments, boost treatment with 23 mv photons? A few places do that and there is some evidence in the literature that that's a good thing, but it's not the standard practice, so when acro goes in and sees that they'll say, you know, we think this is unusual. Why are you doing this? Physician will have to respond to that.

JO BOUFFORD: So, I'm just getting back to this level playing field concept. So, essentially these are the same criteria being applied to hospitals or article 28 facilities at this point in time. They're being applied for accreditation by this third body.

ALEX DAMIANI: Yes, at this point in time this is an across the board article 28, with respect to most of the radiation regulations, they are regulated based on the type of the equipment that you have, not the ownership of the practice or the ownership of the equipment.

WILLIAM STRECK: Just for purposes of the council, if I could, frame the discussion that's before us, not the one that swirled around it before hand or could continue to swirl here, the committee has brought us essentially twin recommendations for radiation therapy and imaging. And it's to pursue accreditation and to initiate data collection methodologies. That's – those are the questions before us today.

The committee spent a lot of time on the more substantial questions, one raise by Mr. Robinson and that's one version of leveling the playing field, and Dr. Martin brought up the other point which is sort of the halfway version of leveling the playing field by incorporating data to one part of the equation. Neither of those recommendations came from the committee who spent hours on this. Now it is the council's prerogative to spend hours on this as well, and so I'm just trying to frame the discussion as to how you wish to proceed on this, and I think the best way to do that would be to ask John to make the motion for the recommendations as presented today, and then we can enter into a formal discussion, and if there want to be

amendments on these broader questions to the recommendations today, that is certainly within the purview of the council members. So John, if you would introduce the formal pathway to resolution here.

JOHN RUGGE: I would be glad to formally make the motion to adopt the recommendations as proposed by the committee.

WILLIAM STRECK: Is there a second to that? Mr. Fassler. Is there discussion about the recommendations as presented to the committee? Dr. Brown.

LAWRENCE BROWN: Just for clarification, the issues about quality that were expressed, is it true that the department will rely mostly on the standards of the accrediting body?

ALEX DAMIANI: We have a combination. We rely on the accreditation for certain aspects, but we also have our own regulations with respect to certain quality assurance elements and particularly with respect to radiation safety elements.

WILLIAM STRECK: Mr. Robinson.

PETER ROBINSON: So, is this the appropriate tie to propose an amendment?

WILLIAM STRECK: This is the time it is allowed to propose an amendment. Yes.

PETER ROBINSON: Thank you Dr. Streck. Then indeed I do. I propose that the recommendations of the committee of which I participated be amended to require article 28 for the private practice of radiation oncology.

WILLIAM STRECK: Is that – article 28 CON review, CON review for the private practice of radiation oncology. Is there a second to that motion?

[Second.]

Mr. Booth seconds the motion. So the motion is now open for discussion as an amendment. Is there further discussion? Dr. Boufford.

JO BOUFFORD: Yeah, it was going to come to this in some ways. I don't know about this particular resolution but it seems to me a year and a half's worth of deliberations in a whole set of domains that John has quite, I think, thoughtfully

and carefully taken forward is really about a segment of the healthcare delivery system which is doing, you know, within a reasonable boundary, arguably of quality or whatever. I'm not impugning what's going on, but it really, if we're focusing on cost and patient coordination of care and moving into systems that we're going to have to cross a threshold at some point. At what point, whether it's a volume point or another point that the private practice of medicine being the way in which you know, huge numbers of very expensive services are you know, growing, we had this – I mean I walked in on the discussion on marketing, I apologize for being late, but it just seems we're coming up to the threshold and stepping back each time, and so part of what I'm struggling for in this process is to say, if this is the only logical next step, then my thought would be at some point there needs to be a look, to make some policy recommendations or some work by this council to make policy recommendations on this issue as we move forward into the notion of accountable care organizations and other mechanisms. I don't know how that fits. I mean, if there's a big private practice of medicine thing doing huge volume, do they all of a sudden, because they enter a governance structure of an ACO begin to be subject to these limitations and decisions? I mean, these are really important issues to deal with, and we've just got something sitting out there that is moving along and we may have gotten as close to it as we can in the current framework, but it

seems to me very unsatisfactory from a policy point of view to stop here and wait three years.

JOHN RUGGE: These are very salient points, and I guess we made the same observations and came to the opposite conclusion and that was that to some degree CON is beside the point here in terms of how utilization and the structure of care delivery is going to be determined. It's going to be new financing arrangements and substituting value-based reimbursement for fee-for-service that would be determinative, and that it may be better to gather more information while at the same time we're learning more about the landscape of radiation therapy we are seeing the evolution of new care modalities. But it's an unsettled area.

JO BOUFFORD: I just – I think one of the dilemmas here is until the payment system from all sources is fully aligned on more of a managed care capitated approach, and it's not clear in the private sector how long that's going to take, this is not going to solve, the market isn't going to solve the problem and these connections aren't going to solve the problem. And I – it just seems, I'd love to have, I don't know what the recommendation would be, Mr. Chair, but there's somebody be, or somewhere this be looked at in the context of the various DSRIPS

and other things that are going on now. Because I don't think it's going to be irrelevant.

WILLIAM STRECK: Are there other comments? Mr. Fensterman.

HOWARD FENSTERMAN: Yes, one of the concerns that I have, it's pretty clear that what we're discussion, there is a necessity, my concern, and it was alluded to earlier in our discussion, relates to the capability of the Department of Health as we are imposing more and more obligations on them to address this and how it effects the Department and how it effects those in the community, the professional community who are responsible now to do what is being suggested. And what's the timeframe, and are there going to be inordinate delays because I think we can all take notice of the fact that the Department's staffing is perhaps not at the levels that it should be and the folks in the Department are working in inordinately hard manner to deal with the volume that they have to deal with. And I'm concerned that we're sort of adopting an approach of "build it and they will come." And I don't know that that's – I don't know what the answer to it is because I think that we have to do these things, and I don't know what the folks from the Department that are here can say about it because they're not really in a position of control where they can

augment their own staffing, and perhaps that's a question for the Commissioner. And it's one that, while I'm not suggesting we put in abeyance the vote, I think that's something we should all be mindful of, because there are folks out there that are going to have to be submitting those, the information and complying with the obligations that we're imposing on theirs, on the other side of the Department that's going to have to deal with it. So I would at some point, either in this meeting or at a later point ask that we address that.

GLENN MARTIN: So speaking specifically to the amendment that was proposed, I'm forced to speak against it, only because at this point we're not even rearranging the deck chairs, we have encountered the deck chairs. And I agree with what everyone had said that there is market forces that don't necessarily work well. There's the possibility for overutilization, there's a lot of moving parts at the moment. CON is probably the completely incorrect way of dealing with the issue, but so, I'm not particularly prepared to support expanding it to other people, but I certainly do support the idea that it would be nice for the Department to have a better idea what's going on, which they don't even know now, so that it can inform changes to the process that are clearly necessary. And it's only for that reason that I speak against it.

PETER ROBINSON: Very valid point, and I understand completely. I have concern about how long it takes to get to the point that you've outlined, and my concern is that the market will move and there'll be a new reality of deck chairs by the time we come around to it which may actually further unbalance the system. So for that reason I respectfully disagree with your disagreement.

WILLIAM STRECK: Are there other observations, comments, on the amendment as proposed. Dr. Bhat.

DR. BHAT: If I understand it, the previous one that we had on the imaging we decided we did not want the private practices to be subjected to the same kind of review as article 28. When it comes down to the current one, what is it that's going to be different?

WILLIAM STRECK: Well, the recommendation is not so that I think your question is best directed to Mr. Robinson. Peter.

PETER ROBINSON: Thank you. Because I do believe that this is a modality which presumably should be pretty limited in terms of demand. You should be able to more precisely figure out how much capacity you need and agree that there is an appropriate geographic distribution so that access is

appropriately maintained. Beyond that, you either have excess capacity that's underutilized or a drive to utilize that excess capacity which actually can jeopardize patient safety. So I think for those reasons this modality because of the high risk nature of it and the critical nature of the patients that are cared by it is an appropriate place to look to start this transition.

JOHN RUGGE: By way of a point of information, by all the information gathered by staff there is no indication of actual overuse of radiation therapy. People aren't getting radiation therapy when it's not indicated. There is concern about advanced RT when simpler modes would be equally efficacious. However, CON does not address this and the current regulatory oversight does not modulate that potential form of overutilization. So it seemed that CON was the inappropriate way to correct possible overutilization in that particular sense, which is again, part of the rationale for going slower and more incremental in terms of this approach.

I think what's at stake is as new radiation therapies open without any evaluation of need, there's a possibility of too many radiation therapy centers and therefore some centers not being financially viable because in the unregulated part of the market there's an opening of new centers. And that's really the salient issue rather than preventing overutilization. So, it's a

matter of considering what market dynamics are in play with, or in this case with extended regulation.

WILLIAM STRECK: Are there other comments? Dr. Brown.

LAWRENCE BROWN: Quick question and a quick follow up; if this amendment succeeds, would this also not be a recommendation to the Commissioner for statutory change since expanding the CON to private providers.

JOHN RUGGE: That's an implication.

WILLIAM STRECK: (Dr.) Delker has suggested that would be the case.

LAWRENCE BROWN: And second, I guess my concern about this is do we have since it's been clarified that we don't have evidence of some areas of overutilization, and there's some issues about concern, do we have any data that actually objectively characterizes this concern? Because my concern about this is if we're moving forward without data given the changing landscape, I'm not sure whether that makes a lot of sense, rather than see the landscape evolve before we make steps of this magnitude.

WILLIAM STRECK: Are there other comments on the proposed amendment? Hearing none, I would ask for a vote on the proposed amendment. So the amendment as stated is to extend the article 28 CON regulations to all providers of radiation therapy which would be an increase over the current application only to article 28 certified institutions. That is the proposed amendment. Those in favor of the amendment please indicate by raising your hand please. And those opposed? So the amendment does not succeed. Thank you. That brings us back to the original motion made by Dr. Rugge that the recommendations as presented by the committee be adopted by the council. That was, there was a motion and a second so we're back to that. Is there further discussion on that proposal? Dr. Boufford.

JO BOUFFORD: If I could just suggest a modification in light of Peter's earlier amendment that it be reported back to the council rather than just be done with any potential recommendations for modification.

WILLIAM STRECK: Ok, so that there is an amendment proposed. Is there a second on the amendment as proposed. It's seconded. Is there discussion on the amendment? Hearing none, those in favor of the amendment as proposed please indicate by saying Aye.

[Aye]

Opposed? Thank you. So the motion as amended is now before the group for a vote. Those in favor of the motion please raise your hand. Those opposed? The motion carries. One abstention. Thank you. That concludes the first report Dr. Rugge is going to give us.

JOHN RUGGE: And now we'll move along with the agenda of the planning committee. We do have a brief report regarding stroke centers and their application across New York and a specific proposal for adding Catskill Regional Hospital as a newly designated stroke center. Anna Colello.

ANNA CARELLA: Reporting from here in Albany.

JOHN RUGGE: There you are.

ANNA COLELLO: Thank you Dr. Rugge. The application from Catskill Regional Medical Center is before you. It went before the Health Planning Committee and we didn't have a quorum but there was a consensus to recommend approval for this an I'm asking the full council to vote for it's approval. It has met the criteria for designation with three contingencies. I've been in additional discussions with the applicant and I believe these

contingencies will be met. But we need your approval before we will do the onsite review where we will verify those contingencies have been met. So it is before you for a group.

JOHN RUGGE: I so move.

[Second.]

WILLIAM STRECK: There's a motion made and seconded. Is there discussion on the motion as proposed? I'm sorry. A motion made and seconded. Is there discussion on the motion as proposed? Hearing none, those in favor of the motion please signify by saying Aye.

[Aye]

Opposed? Thank you. The motion carries.

JOHN RUGGE: That concludes the report of the Planning – oh, I'm sorry. Anna, are you going to be presenting the slides or are those for our review?

ANNA COLELLO: Yes, I can't see the slides, but there are just a few. This is an abbreviation from what was presented to the committee on May 22. It focuses on what the condition of stroke is in New York and in the nation and some studies that

have shown that designation makes a difference. So we could go to the second slide. Based on CDC heart disease and stroke prevention statistics, New York has the lowest stroke mortality rate in the United States. This is based on a 2010 report where New York's mortality was 38.1 percent per 100,000 population where the median for the country was 55.4 percent per 100,000. Stroke is the fourth leading cause of death in the United States but the number one cause of disability, and we believe in part that New York State has done so well based on stroke designation. It is not the only factor but it is certainly a major factor that looks at the system of care approach both in the hospital and incorporating EMS that has made a difference. There are 119 hospitals that are currently designated in New York including some rural counties. I'd like to note that the last four or five applicants that have become designated have all been in rural counties.

So we believe that primary stroke center designation, if you could go to the next slide, is something that can be achieved by all hospitals in the State. We welcome the addition of others and with regard to rural counties, as I've just pointed out, some have been able to meet it and we are going to work with the office of rural health and Karen Madden to conduct a survey to see if there are any other barriers for why not all hospitals have chosen this route.

The designations requirement center around the importance of a stroke team, education of both staff within the hospital, the patient and the family with regard to the signs and symptoms and how to prevent secondary stroke. There's a requirement for twice a year for EMS education and the community outreach as well. Stroke designation is based on capabilities 24/7 in a number of areas including imaging and neurosurgery whether it's on-site or with a transfer agreement to a center who can provide it within two hours of when it's needed, labs in that timeframe as well. Not the two hours but within 45 minutes. And a quality assurance component, and that quality assurance component is very significant in that we collect information on five time targets. As you know, time is brain so focusing on the speed at which once the patient is in the ED how quickly they get treatment is dependent on meeting certain time targets and also performance measures. I'd like to applaud the hospitals that have chosen to be designated because they are very compassionate stroke coordinators and staff that strive to meet those performance measures and it's through the American Heart Association and the hospital associations that work with us to support the hospitals to keep meeting those improvements. The State also has a grant that 45 hospitals have chosen to work with us in a more focused basis to improve even further, again, showing the commitment of hospitals to do that. Next slide please.

This was a study that was recorded in JAMA that used New York State data that illustrated that designation does make a difference both in the metropolitan New York area as well as the upstate area. Designated stroke centers have a lower mortality than non-designated centers. Next slide please.

This shows the rate of discharges resulting in in-hospital mortality using SPARCS data from 2003 to 2011 showing the stead decline which we do believe, as I said, in part is attributable to designation. And another measure of performance which is significant specifically for ischemic stroke patients – next slide please – is looking at the rate of TPA administration and looking at how it is in New York State designated centers versus non-designated centers. The rate of administration of TPA has gone up for both groups, but more significantly for the designated centers.

Stroke mortality is not the only way to look at quality performance and we will be meeting with our stroke physician advisory group to study that. What is the best way to represent the data on quality and in the Office of Quality and Patient Safety we are also examining the possibility of a risk adjusted stroke mortality rate to be reported, but that is under consideration with our stroke physician advisory group. And that concludes my report.

JOHN RUGGE: Very briefly would note that even though rural counties are achieving stroke center designation deeply rural counties, not the case. There are no stroke centers north of the Thruway, and it was suggested a committee that telemedicine may be one modality to promote stroke ready if not stroke designated centers. More work would seem to need to be done to assure statewide coverage.

With that Mr. Chairman, I conclude my report of the Planning Committee.

WILLIAM STRECK: Thank you. And that stroke data is interesting that we can't just ignore the fact that a state initiative, I mean and state and national initiative we can really demonstrate fundamental changes, and to have New York State in the lead should be noted. So now it's my pleasure to welcome acting Commissioner Zucker to our meeting. Perfectly timed arrival here as our schedule has unfolded, and most happy to have him make his inaugural remarks to the council.

HOWARD ZUCKER: Thank you. Thank you very much for having me here. I'm sorry I couldn't come down earlier. Schedules as you all know sometimes change a lot.

It's a pleasure to be here. I'm thrilled to be here at my first PHHPC meeting as the acting commissioner, and I've sat in on the meetings over the course of the past eight or nine months

and I have been most impressed by everything the PHHPC committee has done. It's a vibrant and vital component of basically the governance of a lot of what we do here in public health, and has the best medical minds and the best health minds that are out here, and under the leadership of Dr. Streck you've considered a range of matters that have been critical to the importance of public health for the State of New York and for – and in many ways because of the State of New York a lot of what we do is important to the rest of the country in a lot of ways for across the country.

As an aside, I'd like to congratulate Dr. Streck on his recent retirement from Bassett. We had a nice conversation about that and I am always impressed by those who dedicated a long service to institutions and I congratulate you and all your hard work.

Time and time again we've looked in fulfilling the missions of what we need to do and the recommendations that have been put forth by all of you to the State, and I look forward to the next aspect of what the council will do on building on the different areas that you have done. You've taken on uncharted territory so you've crafted recommendations that ensure the health and safety of all the patients that use ambulatory care. That was one of the issues from last year which we were talking a little bit about, and I know the council has more work to do on that topic, but I'm sure that ultimately there'll be a very

thoughtful and well – very thorough I should say, report that you'll provide.

In this, the council and the committee has recognized the importance of regional planning and I'm pleased to say that the Department will be issuing a request for applications allowing us to establish a population health improvement program. And we will chose one PHIP contract for each, reach from the State to provide a neutral forum for identifying, for sharing, and for implementing the best practices and strategies to promote population health. And as many of you know, the population health summit that we had in December of last year was incredibly well attended and really has set the pace for much of what we are doing within the Department. PHIP will also work to reduce healthcare disparities in their respective regions.

In addition the council and the Health Planning Committee did an excellent job analyzing issues and options for redesigning the State's Certificate of Need. I was mentioning to Dr. Streck this morning having been on the other side of that one, I was working in one of the medical centers here and trying to get Certificate of Need and I remember everyone saying, well, the State has to make this decision. I remember saying to myself, "what does the State have to do with fixing, building something? The State has to approve this?" and so I stood there once in this ICU, I looked around, and I said, "when do we open

it?" and they said, "When the State tells us to." So now I'm sitting here from the other side.

Many of your recommendations were implemented about this and it resulted in a streamline process for a CON applicant. And this given me the opportunity to acknowledge the work of the council and the Establishment and Project Review Committee in considering these CON applications. Similarly I would note the contributions of the council and the codes committee and it's role in reviewing regulations such as those pertaining to facility standards and the State's sanitary code.

The council, with the help of the Public Health Committee oversaw the development of the State's Prevention Agenda, and this agenda is not only guiding our public health efforts in the State and forming the basis for our national public health accreditation effort, but it's also integral to the DSRIP program and the upcoming SHIP plan or the State Health Innovation Plan, the SIM grants applications that are out there.

The, Gus and I were speaking yesterday a little bit about public health – Gus Birkhead – and all the different possibilities of where we can move forward on this and all that we have done over the course of the past three, four, five years and particularly some of the key things under leadership Dr. Shah as pushed forward.

Following hurricane Irene and Lee and Superstorm Sandy, the council convened an ad-hoc advisory committee on environmental

construction standards and the committee issued a series of recommendations that enhances the ability of the State and it's health facilities to prepare for and respond to natural disasters. We continue to look at this and particularly every year depending upon what time of the year it is, what potential storm could come our way. All your efforts and dedications have helped put the State in a better position to address the emerging issues that impact health and healthcare in New York State and across the New York area.

Now we're on the brink of a new era and new challenges and new ideas that have to be put forth. So we have the Prevention Agenda, the SHIP and the DSRIP programs and they offer unprecedented opportunities to achieve the transformation of our healthcare system. But these initiatives will allow us to continue our efforts to among other things, encourage the integration of services across multiple and diverse providers that we have. New York has been a leader in incorporating behavioral health services into primary care and we've seen this in the Medicaid Health Homes. This whole issue of behavioral health is center to many of the teams that work within the Department of Health but I think it's centered to the community in general and we are very interested in making sure that we address this. So the Department has been working with the Office of Mental Health and the Office of Alcohol and Substance Abuse Services or OASAS on a pilot project that integrates

primary care and behavioral health services in clinic settings. We will continue to support this endeavor in any way that we can and we are also working to better integrate the public health and clinical medicine roles together and this brings together a recent IOM report that has been called for on this issue.

Now I'd like the challenge the PHHPC members to expand our thinking and explore new ideas. So, for example, I'd like to ask the committee to generate some ideas of possible topics that we can look towards as we move forward then present them to Dr. Streck, Dr. Rugge and to myself as to where, what else we can do, what we should be tackling as we move forward in healthcare and healthcare delivery and public health, primary care and all these different areas that we are looking at.

And I'd really like to sort of harness the energy, the wisdom, the talent, the knowledge that all of you have here to address these issues for all of New York as I know in just looking around the room the years of experience and the knowledge that you have and I think that it'd be very helpful to the Department as we try to tackle new areas, new initiatives that come forth.

We need to focus on the issues that will have the greatest impact to the greatest number of New Yorkers with the spirit and the essence of public health at the center of all this and it sort of amazes me over the course of the last eight or nine months of how many issues the Department of Health tackles and

how it touches on the lives of so many people in so many different ways that you don't even – well, all of you realize this but I don't think you know, the – even my medical colleagues, I don't think they sometimes realize that you know – I was talking to some of my colleagues when I was practicing and they didn't realize how much health, how much the Department of Health touches into the lives of somebody, their life in so many different areas.

We need to recognize how do we continue to push forward on public health for all our citizens and how can we continue to support our local public health infrastructure and assure that public health and clinical medicine are on the course towards further collaboration as we tackle the problems that are before us. And what can PHHPC do to make sure that patient safety and patient quality continues to move forward. I know we've done a lot in the course of the last couple years on this, but we need to keep pushing – pushing on the issues of quality and safety for all New Yorkers and making sure that patients get the excellent care independent of where in the State they reside.

While we're at it we need to look at new models of care even as we grow our patient-centered medical homes. What can we do to cultivate these new models of care and perhaps we'll find new ones as the DSRIP process moves forward.

So these are just a few of the questions that keep rolling through my head and as we sit down (in our senior staff

meetings) to discuss, but I'd like to just bring up a little bit of what has been happening in the Department.

So, the IAF which is the funding we've been able to receive applications from all five of the major public health systems in New York State for IAF funding, and I'll go through that in a second, we've heard from 11 HHC hospitals, three SUNY hospitals, the Erie County Medical Center, the Nassau University Medical Center, and Westchester Medical Center. They are asking for more than double what we have available, which is they want $543.9 million in the requests for about $250 million available funds that we have. We also got applications from about 24 safety net hospitals, as well. So we are now in the middle of the review process and expect to announce the awards by the end of June and then we'll be an ongoing contracts with the awardees that are out there. We are also looking to working with them while they are restructuring the part of the Performing Provider Systems, as we work towards applying the DSRIP money.

DSRIP, which is—you know how sometimes in life there's an acronym that just stays with you forever, well this is one that has surfaced, and I will tell you the delivery systems reform incentive payments system program has been a critical issue as we continue, and all of DOH staff has been involved in this, and they are releasing new materials on this every day. Jason Helgerson has been, and his team, have been extremely hard working in this and as some of you may know, Jim (INCHON) has

joined in our office to work on moving this forward, as well. The DSRIP website is available on our website, www.health.ny.gov, and then just "slash DSRIP"—DSRIP, obviously. And it includes the official documents from CMS, it frequently asks— has all the frequently asked questions. It has glossary of information and we are trying to keep this transparent so that everyone has as much information as they need. It has a number of webinars that have been tailored to specific provider types. The DSRIP project toolkit has been put forth, the performance data information is there, and a list of emerging performing provider services systems that are also intended to apply the DSRIP funds and DSRIP grants that will be put forth. We've also added several DSRIP white boards, which are short YouTube videos focused on the key elements of DSRIP. I recommend people look at them, they are very well done, and I think they would be very helpful to get a grasp of some of the issues that will be moving forward on this if you have questions. And then there's the DSRIP project design grant application which is due in a couple weeks, June 26th, I believe. The emerging PPSs will apply for funding to support the planning efforts to complete the DSRIP project plan application. And the DSRIP project plan applications, those are due on December 16th. But actually, on the website, if you looked on the website, there's also information with all these deadlines and dates, as well.

Members of the public who are interested can stay appraised

[sic] of the latest developments by signing up to the MRT listserv and that will give you information, as well, and all the instructions on all the… on the website as well.

We all recognize that this is a big task before us on the issue of what we're trying to do, but we all believe that once this is set into motion and we move forward that it's definitely going to be better for the health care delivery for the state and I think that, as someone said to me, that change is… sometime can be a little bit, it's a little creative, and it's a little messy, but when you are done it's usually for the best and I think that that's where we are. This is a lot of change, but I think that it's in the best interest of all those who will served. And I think that we are moving in that directions.

Other areas are maternal hypertension. The Department is also in the midst of efforts to help provide patients to better manage hypertension in pregnancy. We started by looking about 215 maternal deaths that occurred between 2006 and 2011 and our comprehensive surveillance showed that a leading cause of death was hemorrhage and hypertension. So based on these findings we made a priority to develop a guidance document for the management of hypertensive disorders during pregnancy, or HDP, and that document can be used by all members of the mother's care team. In 2013, the Department of Health released this guidance document and the final version was posted on the website and sent to hospitals across the state so that they are

aware of what— about the information we have. DOH has also successfully applied for a highly competitive, Every Mother Initiative grant, from the Association of Maternal and Child Health Programs last year. And the grant will be used to launch a campaign to educate health-care providers and patients on hypertensive disorders in pregnancy and as part of this initiative, the Every Mother Initiative project team, the Department and the external clinical experts have been working to create a body of user-friendly point-of-care tools, including posters, other things that will highlight the proper techniques for blood pressure management, preeclampsia, and early, all the early signs of concern that may develop as a result of hypertension and other algorithms that will be helpful for both preeclampsia, as well as preeclampsia, and management in the emergency department and the other parts of the medical center, as well. I think that we sometimes don't recognize how issues that sometimes people take for granted are not and these are critical issues— or health care that's deliberately taken for granted, but these are somewhat critical issues, particularly for maternal health. We are doing a PowerPoint presentation of hypertensive disorders in pregnancy and that will be available to the providers once we have that together. And the Department has also been working with the Preeclampsia Foundation to secure patient education materials on the signs and symptoms of preeclampsia.

I, yeah, before I did this, I practiced pediatric cardiology and one of my patients— they grow up, right, everyone grows up— and so she was pregnant, is pregnant, and she like, her mother called me because I am still in touch with them and she said, "I think she's got some high blood pressure, this and that…" I said, "You know, she may be preeclamptic." So there I was, having this conversation on something which is so far from pediatrics, but I realized that this is a big concern and I am glad that the state and all of us are working on this.

The next issue is flu season and hurricane season. So, I have good news on this and I have bad news on this. The good news is that the flu season is over; the bad news is that the hurricane season has just begun. It seems like it works that way, one ends and the other one begins. But we have good news on both fronts on this. So with the flu season, it officially began December 19, 2013. We had two consecutive waves of influenza this past year and they were two different types of flu—we had the H1N1 struck in December and peaked in January, continued until February. And then we had influenza B that came in early March, peaked the first weeks of April, and continued into May. This was the first year New York had a flu mask mandate, which required health care personnel to wear a mask if they didn't get vaccinated. Now I am sure you remember this was put forth and we were saying that only 54 percent of the health care workers in New York were vaccinated and so Dr. Shah made an effort to say

"Well if you don't you have to wear a mask," and it went up to 88 percent this year, so that really worked very effectively. I will tell you that back in the fall I went for a— my hip was bothering me so I went in for a MRI and the health worker, health care worker who was there was wearing a mask and I looked at her and I said, "Guess you didn't get your flu shot," and she said "No, I haven't got my flu shot and I can't believe the state is telling me that I have to do this." And little did— she had no idea that— she didn't know I was a doctor or anything at the end of it and so I went into the scan and I came out of the scan and I said, "You know, can I look at my scan to see what it shows?" And they said, "Well, your doctor will tell you." I said, "Actually, I was a doctor in this hospital and I am still a doctor. I wouldn't mind." And they said "Are you still working in the hospital." I said, "No, no, I am not." And they said, "Which hospital do you work at?" And I said, "I actually work for the State," and I said, "I am part of the team that told you, you have to wear that mask." And they just looked at me and I said "You never know who is going to be standing there." So Dr. Shah's instincts were accurate in saying that we should have those who are not vaccinated wear a mask and I bet you next year instead of 88 percent, I bet you will up in the 90 percent, which is an awesome success rate. So, we benefitted from this policy, but more importantly, obviously the patients have benefited from it because they are less at risk.

So, now we go on to the other issue, which is the hurricane season. I think we could all agree, this weather has been quite unpredictable for the past couple of months, even today. Every day is different. So, I am reluctant to try and predict what kind of season we'll have, but we will be ready for this. For many months, the Department of Health has been working with the City Office of Emergency Management, the City's Health and Mental-- Department of Health and Mental Hygiene. The local health departments, the emergency management on Long Island, Westchester County, and all across the area, and obviously all across the state. Together we're updating the New York City coastal plans to include a new version of the health care facility evacuation center plan. I know for those who are part of the hospitals down here in the area, this has been in discussion probably within your medical centers, as well. DOH is working on expanding the HCEC across the state—the Health Care Evacuation Centers—across the state to ensure that we have the same capabilities in areas that have been most effected by significant flooding from hurricanes and tropical storms, but were not necessarily coastal counties. The health care facilities throughout New York City and the surrounding metropolitan area have been trained in the HCEC concepts and operational requirements including the eFINDS. And Patsy has worked, we worked when we were in your other capacity a lot on these issues and so I thank you for your work on that. Our

Department is working with the VA to expand the use of eFINDS to the facilities throughout the state. As you recall, the eFINDS systems are electronic tracking system that allows hospitals and nursing homes to keep track of residents and patients in the event of an emergency. Just the other day, Sue Kelly, the executive deputy commissioner gave me an article from one of the papers right here in the city, one of the community papers, about how they were doing a study and… just sort of a look at how effective they could move some patients and they mentioned right there in the article the State's eFINDS program and the effectiveness of it. Many facilities in New York City and across the state have already conducted the eFINDS exercise and have had great success in using the system. We are also conducting the health emergency response data system, or the HERDS, surveys in New York City and the metropolitan areas, to provide up-to-date information on send and receive arrangements for potential evacuation operations and that is a big issue as we have spoken about in the past about the need to make sure that those who need to be evacuated, particularly, you know, when someone is extremely vulnerable, not only just in the hospital, but nursing homes and elsewhere, people become extremely vulnerable, and when you have a crisis, particularly a storm, it makes them even more concerned. I think about this from the standpoint of even if somebody is just at home and they are frail, that's one thing, but imagine being, you know, in a health care facility

and frail and not have your support of your relatives in a storm—there's a lot of anxiety, I guess, that it would produce upon, not only the patient, but everyone involved. And, clearly, you know health care workers are trying to do everything they can to help many people at one time.

We are—the DOH is also, we're also urging the use of HERDS on the health commerce system to survey participating non-disaster medical systems, hospitals throughout the state that are not part of the VA system, as well. In addition, we're developing facility profiles and shelter-in-place operational guidelines—and this is really important— it will be provided to health care facilities in New York City, because this is an issue that was raised after Hurricane Sandy, when can you stay and when can you leave and as everyone knows that storms do vary and Mike Primo and NICK and I have spoken a lot about this, about the need to try to predict things, but you cannot, you really can't outsmart Mother Nature sometimes, and sometimes you really, you're caught. These guidelines will provide a better handle of where they are going to send their residents in the event of an evacuation and whether they have the inventory to accommodate incoming residents who might be sent there. It will also help them prioritize their preparedness activities for this year. And in August we'll conduct the executive-level table-top exercises here in the City on the coastal storm plan, which will probably take place right in this room, which will

further prepare us for any hurricanes and as a matter of fact, it was the first event that I attended when I came into the Department last September. Actually it was last August when we did it. And to make sure we work in a timely fashion during an emergency, the Army Corps of Engineers is performing a hurricane evacuation study to determine the validity of the evacuation timelines for the general population, as well as evacuations of health care facilities, which is also critically important. We don't want to both duplicate our efforts, and we also want to make things as streamlined as possible.

I would like to sort of wrap up by just saying that we— the Department— has an excellent team. I have been obviously in this role for what, three weeks now, four weeks? It feels like maybe it's two months, but I don't think so— three or four weeks, but it feels like two months. But the one thing I have learned is that we have an incredible team of hard-working, dedicated, extremely bright health professionals and just team in general from all different areas and we are trying to move forward in a lot of different areas, whether it's the DSRIP issue, the SHIP, the Health Innovation Plan, whether eFINDS and the emergency preparedness issues, or for that matter, all the other areas that we are doing in public health—Gus Birkhead's shop on issues of flu, and the AIDS Institute, we were talking about this just yesterday—and so it is a privilege to be part of the Department to be able to lead the team of experts that are out there, but

we really do turn to all of you, the expertise that all of you have and the guidance that you can provide us as we move forward. And sometimes when you are on the inside you don't have all the perspective and it's helpful to have those on the outside give you a little perspective, so I am available. My phone is always open to any calls or suggestions that you may have. Please contact me if you think that there's something that we should be doing as part of the Department differently. Let us know if you think there is something you think we should be doing that we're not doing, let us know. And the goal is to make the health of everyone in New York better and that's why everyone in the Department is here and that's why I surely am here and thank the whole PHHPC committee for all your dedication and the time you take to serve here. So, thank you.

WILLIAM STRECK: Thank you, Commissioner. Are there comments or questions for the Commissioner? Dr. Palmer.

DR. PALMER: Welcome aboard. Your enthusiasm is great and I hope it stays at that same level going forward. One of the things that we have been hearing recently in discussions about certain regulatory functions the Department has to… it has responsibility for, is the staffing—that the Department is not saying we don't have staffing, it's are these particular areas covered? No they are not. We are in arrears in monitoring these

areas. So it's been that kind of discussion that we've heard and there's some issues that came up today that go back to the question of is staffing adequate or is there going to be a re-engineering within the Department so that staffing issues don't become such a strong part of regulatory issues not being followed up on?

HOWARD ZUCKER: The issue of staffing, I just was talking to Mike NIZARCO, who is— about some of these issues yesterday and we're going to try and look at that a little bit closer. So, I don't have an answer for you yet on this, but it is something which is on the radar because I actually… we just were talking about this at 2:30 yesterday afternoon.

WILLIAM STRECK: Other comments or questions for the Commissioner? Well, thank you, Commissioner. We know you have a very tight schedule today.

HOWARD ZUCKER: I'd like to stay for the— I just have to catch a flight and so, otherwise I will, any time I can attend the meetings, I definitely will. I know I am back and forth to Albany, so if things are in synch, I definitely will be there at the meeting and available, and, like I said, anything I can do to help, please let me know. Thank you.

WILLIAM STRECK: OK. We will now turn to Department of Health reports and the first report is from the Office of Primary Care and Health Systems Management Activities. Mr. Servis.

KEITH SERVIS: Thank you. Good morning. Dr. Zucker told you all about most of the major initiatives that we are working on, so I will really just touch on one item and that is that we have a new leader. Mr. Dan Sheppard, who comes to us as a long-time director from the Division of Budget, is going to be the new Deputy Commissioner and Director of OPCHSM. Dan sends his apologies for not being here, but he's, as you can imagine, stuck in session for the next couple of weeks, and you should expect to see him at the next meeting. He will be starting with us a week after next on a full-time basis. Thanks.

WILLIAM STRECK: Questions? Next we'll go the Office of Health Insurance Program Activities. Miss Misa from Albany, I believe.

SYLVIA PIRANI: Hi. This is Sylvia Pirani. I am covering for Liz Misa briefly who had to leave. She just wanted to thank Dr. Zucker for presenting. [technical issue]

WILLIAM STRECK: OK. Thank you, Sylvia. A deep-dive on DSRIP sounds very intimidating, so I want to look at the agenda for that meeting before we get too, too deep in the dive. Are there any other comments for Sylvia? OK. Thanks. Thanks much.

SYLVIA PIRANI: And I am also covering for Gus Birkhead, who also had to leave.

WILLIAM STRECK: Well, do proceed. That's fine.

SYLVIA PIRANI: Good. So, one of the things that Gus and I have been working on is, in fact, making sure that the population health programs and the programs in the Office of Public Health are integrated into the DSRIP implementation and we did complete and post on the DSRIP website a tool for how Performing Provider Systems can conduct the community-needs assessments that are a requirement in the DSRIP applications, linking that to the Prevention Agenda. And then Gus also wanted to just inform everybody and remind people that next Tuesday and Wednesday is our accreditation site visit by the Public Health Accreditation Board, who is sending three public health practitioners, including the public health director from California, a local public health director from Florida, and a deputy commissioner from the State of Washington Health Department to Albany Tuesday and Wednesday. We're having

sessions on Tuesday on each of the 12 domains in the accreditation process, which links with the 10 essential services. And then on Wednesday we are having a meeting with representatives from the governing authority; that would be the Commissioner and the Public Health and Health Planning Council, so Dr. Streck, Dr. Boufford, Dr. Rugge, are coming up in person— AL MATENBERG, Mr. Kraut, and others are participating by telephone, so thank you very much for joining us for that session, and then immediately after that session they are also meeting with members of… representatives of our community partners and some of you are staying for that, as well. So, we are excited about this site visit. We are especially excited that it will soon be over, because it's been a huge amount of effort to prepare. It's the final step in the process and we anticipate that the PHAB board will make a decision and announce it in September. So, thank you in advance for your participation next week. And that is Gus's report.

WILLIAM STRECK: Thank you. The seriousness of this review is, if it's indicated by the extent of the agenda and the meetings that have been scheduled for this accreditation, it's really quite extraordinary, so the Department of Health will be understaffed next Tuesday and Wednesday. They will all be in these meetings. OK, thank you, Sylvia.

SYLVIA PIRANI: Thank you.

WILLIAM STRECK: So we'll now move to Public Health Services, Dr. Bouffard.

JO BOUFFORD: Yes, just an update since our last meeting. We did have another meeting of the ad hoc leadership committee, which is also the steering committee, if you will, for the accreditation process, on May 28th. It was very well attended in three locations and we had our first formal presentations from representatives doing the DSRIP and the SHIP and the PHHP, so we felt like we were finally part of the team here, sort of putting the population health issues that are well integrated and very good discussions with all of them—Hope Plavin was present and Lisa ALTMAN. Gus filled in for Jason; I am sure Jason never gets anywhere he's supposed to be these days, but it was a very good discussion and we're very gratified to see the links to the Prevention Agenda. Our hope is that by connecting these dots as people begin to revise their… brush off or refresh their community health needs assessments going forward for the DSRIP application process, a lot of the work they will see they have already done in the context of preparing for the Prevention Agenda and that the coalitions that are already created in the communities can be quite helpful in tackling some of the problems that are options for people for health systems to

select. We also had a very nice review and analysis by Sylvia Pirani and her colleagues on the results of the plans that were submitted in November and they are all, all of those details are posted on the website, but just for your interest, the local, the health systems and hospitals and the local health departments collaborated in discussing the submissions—although the submissions were still technically separate—but happily the concordance was quite high so that the five priorities for the Prevention Agenda, 98 percent of the local health departments identified prevention of chronic disease and 96 percent of the hospitals identified the same. A lot of work on obesity there and then a little bit of divergence on cardiovascular disease, versus diabetes, versus cancer.

Second for both was the promoting mental health and preventing substance abuse—50 percent of all the local health departments and 42 percent of the hospitals submitted proposals there—so that was, I think a very, not a surprise exactly, but it was a quite-important affirmation of the broader informing of the priority setting by the ad hoc leadership group. That list, because that substance abuse and mental health are not under the control, if you will—staff are not of the Health Department—they were not on the original list of candidates for the Prevention Agenda; they were added after considerable input and discussion from the ad hoc group, and you can see the response is very reflective of their judgment of reality in the communities. And

we have had terrific collaboration with the Mental Health, Office of Mental Health and OASAS on the planning and implementation. We're expecting to be very engaged with them going forward.

WILLIAM STRECK: If I could…

JO BOUFFORD: I am sorry, yes.

WILLIAM STRECK: Just some wordsmithing there. Was the phrasing "preventing mental health and substance abuse?"

JO BOUFFORD: Hopefully not. Thank you. It was "preventing substance abuse and promoting mental health."

OK. Alright.

Yeah. I hope I said it that way. I was sort of reading it off the paper, so I hope I didn't make a mistake. Those get flipped often, yes, I understand that. Yeah, anyway. Preventing health services, yes. The third, fourth, and fifth were healthy women, infants, and children; again, similar number in both promoting healthy and safe environment. That's an interesting one because it implied a good bit of intersectoral [sic] collaboration on

built environment and with the state EPA and it was gratifying to see some of the local areas come forward with those looks at ranging from fluoridation from parks revision and other things, so we are hoping to see more of that going forward. And finally the sort of backbone of public health, HIV and vaccine-preventable diseases, was selected by a little under 10 percent of both sides. I think the… we discussed that in the ad hoc leadership group. Concerns has HIV gone off the boiler, some of the other areas, and I think the sense was that these are so built into the funding streams and the sort of regular engagement both on the local health department and provider side, they are already having to report results there that may be we need to check, but that they were sort of assumed to be in the works and therefore did not get kind of special attention in this process, but we're gonna check that out, cause people were a little concerned about that.

The other things I'd say about that. We have— this process has been able to attract funding. I think we mentioned last time that the New York State Health Foundation had provided a matching grant of a half-million dollars to communities that are implementing the Prevention Agenda to support that work at the community level. Twenty-eight local health departments and their partners really submitted work, were granted funding, and they are, most of them, are able to meet the match. And this is where I think these community teams come in, where businesses are

stepping forward, hospitals are stepping forward, and others, too, or local foundations, too, to make the match. And the size of the grants range from, you know, under $25,000 to a little over $150,000, so it was an opportunity really for the small health departments to compete and be part of it before the minimum had been set at a level where it was mostly just the large regional bodies. And similarly, the New York State Health Foundation, in April, awarded a grant of $400,000 for and additional technical assistance for the prevention of chronic disease and the promotion of mental health and prevention of substance abuse communities and that work, they have already had their initial meeting; that work is underway. That will take place over the next 18 months to help communities especially focus on developing robust and clear partnerships and defining their goals and metrics for measurement and getting underway. So that's encouraging and the New York State Health Foundation, I think, is to be thanked for that and they are also in… seeking other funds. They are in, they and the State, are in conversation with the Robert Wood Johnson foundation, other groups.

So, finally on the ad hoc group, we had a set of pledges. There's a very nice measurement on the website, I should say the metrics that are being used, and if you go on the New York State Health Department website, you will see a new button. We had a blue button which was a bit boring, so now there's a button

that's green, largely green, but it reflects really the cover of the Prevention Agenda brochure, which is really a community in microcosm, it's really quite nice. So you go there and we're herding everyone to take a look at it, cause it really provides them the tools they need to move their work forward. We had a number of public pledges from members of the ad hoc leadership group to engage at the local level. This is really the critical point where recently posted, thanks to the YO PERSONS task led by Sylvia of really who are the individuals at each local health department and each hospital that are leading this process and what are the— how do you get in touch with them? Who's on the various community-based coalitions? So that in the instance of the hospitals, they can see—and the community health centers—CHCANYS has really made a pledge to look at each community and try to get… and encourage their community health centers locally to join these coalitions and really begin to engage in this work. The New York Business Group on Health has done the same on the business side and they are going to be meeting with the New York Business Council, who has been a member, but not able to be that involved and a number of the NGOs and others—Latino Commission on AIDS, especially, had stepped forward and offered to be very helpful in mobilizing local community support. So, this is an important step; we'll be tracking this engagement. This group is very enthusiastic. I am sure a number of them will be at the accreditation site visit

meeting and we'll be meeting again in September and we are still feeling an inadequate response on the disparities side. I think while a number of the many, many of the proposals that came in did address a health disparity as they were required to, the sort of robustness of their planning was not what we had hoped to see and this has been an issue that has been carried all the way through. We did do, I think, a really nice job of putting guidance on the website, technical assistance, but we had hoped to get additional funding to do more work in that area, but as a result of that, the… several members of the ad hoc leadership group—Luis Rodriguez from the New York State Health Foundation, Lloyd Bishop from Greater New York, Guillermo Chacon from Latino Commission on AIDS, Cheryl Hunter-Grant of the Associated Perinatal Networks, Cheryl Healton at NYU, and a representative from the New York State Minority Council agreed to participate in a work group with the State Health Department to really try to take a deeper look at what has been proposed at the community level and the nature of technical assistance and support that may be necessary. We know that the State has a number of national and global experts on the issue of health disparities in our academic institutions and others and we just need to really link them more closely to what's going on at the local level and regional level. So that's my report. Thank you.

WILLIAM STRECK: Questions or comments for Dr. Boufford? I have one. The low-ranking vaccination, the anti-vaccination crowd and… I mean is that an emerging concern in terms of the… I mean the measles epidemic that's out there.

JO BOUFFORD: Yeah, I mean that probably would have been a question for the Commissioner. I think the immunization rate for kids is built into the women's, infants', and children's goals, so it's getting a double… it will get a double run through the Prevention Agenda, but I don't know specifically. We haven't heard that that's been an issue that would rise to the level of these coalitions, but I mean it's certainly something that should be a concern to all of us, I think.

WILLIAM STRECK: Dr. Brown.

LAWRENCE BROWN: Unrelated to that question, the issue that—and I am glad to hear that there is greater collaboration with OASAS and OMH, Department of Health, particularly in the era that we find ourselves with prescription drug abuse and heroin overdose. I was wondering if you might be able to add whether there were any efforts by— based on that epidemiology MAP that we're currently in the midst of, have there been any efforts to have collaboration across the departments to be able to respond even more effectively, particularly given the high

prevalence of co-occurring health and mental health problems among those who, in fact, use substances.

JO BOUFFORD: Yeah, this is— this work in the mental health and substance abuse area is very much within all three agencies are engaged; they have been from the beginning. They were very involved in developing the sort of evidence-based goals and objectives, the metrics, and the sort of evidence-based interventions that have been shown to have efficacy and they are now very involved in mobilizing to implement because the mental health community and substance abuse community have actually infrastructure in a number of regions and communities that will be very helpful in this process, so they are very involved.

LAWRENCE BROWN: And the reason why I think this is particularly important because those of us who have seen the report from the Senate task force have felt it has been mostly law enforcement emphasis and less from a health emphasis.

JO BOUFFORD: Yeah, there has been an, actually I'll slightly and modestly say my organization, New York Academy put out a blueprint for a sort of shifting from a criminally-justice driven approach to drug policy in New York State to a public health approach and we had been working actively with the

criminal justice coordinator for Governor Cuomo, who left unfortunately, and has been succeeded and we have not been back up and talking to them. They had been quite, I think, embracing this, as had the City leadership in the substance abuse area, but it is certainly, I would hope that— I think the Senate has been quite a leader in really wanting to look at the implications of the so-called Rockefeller Drug Laws in New York State, so we will take that on board and bring, certainly bring those reports and that to the attention of the local communities that are working on this.

WILLIAM STRECK: Other questions or comments? Thank you. We'll now move to the project review recommendations and Establishment. Oh, no, we won't. We still have. Pardon me, Dr. Palmer. Work ahead here. We have the Regulations and Codes Committee, so please proceed.

DR. PALMER: Thank you. The last meeting, May 22nd, three regulations were reviewed. We did not have a quorum, but they were advanced based on consensus vote for consideration to this meeting and adoption. Those three regulations were: section 400.25 of title X, disclosure of quality and surveillance-related information; sections 405.13, 405.22, 405.30, and 405.31, title X, transplant services; and section 1.31, disclosure of confidential cancer information. I am gonna read

from the summary so folks can get an idea of what the issues were before we take them to a vote. Is that fine? Miss Asgard, from the Office of Quality and Patient Safety—and this is related to 400.25 of title X, disclosure of quality and surveillance-related information—made the presentation from Albany. Miss Leslie and Pappalardi from the Office of Primary Care and Health Systems Management were also present. Miss Asgard explained the regulations are to finalize implementation of Nursing Quality Act—NCQPA—of 2009, this law is based on research initially established in the late 1990s identifying valid and reliable, nurse-sensitive quality indicators in hospitals. These indicators are collectively referred to as the National Database for Nursing Quality Indicators. Around the same period of time, CMS was working to identify quality indicators sensitive to nursing care in nursing homes. The regulations state that upon request every general hospital and residential health care facility must make available to any member of the public and to the Commissioner of any state agency responsible for the licensing or accrediting a facility or responsible for overseeing the delivery of services, either directly or indirectly, information regarding nursing quality indicators and surveillance-related information. Guidance on compliance with NCQPA was issued by the Department of Health to general hospitals and nursing homes in March of 2010. Both the guidelines and these proposed regulations were drafted with

input and in collaboration with key industry stakeholders and the New York State Nursing Association. The regulations were published in the *State Register* and one letter was received from the New York State Nurses Association. The Association raised concerns that proposed regulations… that the proposed regulations not written to apply to all article-28-facilty types, that there form and timeliness of data disclosure was not consistent with the statute, and the possibility that non-direct nursing care staff would be included in staffing indicator counts. NYSNA made public comment during the committee meeting and reiterated these concerns. Upon request of counsel, Miss Asgard responded that nurse quality indicators included in the proposed regulations had been determined to be valid and reliable in hospitals and nursing homes only in that the law included language which supported limiting regulations to applicable settings. This is the end of the information coming from the presentations from the state. Are there any questions? Well, we'd like to move to have this regulation accepted.

[Second.]

WILLIAM STRECK: There is a motion and a second for adoption of the regulation. Is there discussion on the motion as proposed? Hearing none, those in favor of the motion as proposed, please say aye.

[Aye.]

Opposed? The motion carries. Thank you.

DR. PALMER: Thank you. Next regulation is section 1.31, disclosure of confidential cancer information. Dr. Sherman from the Bureau of Cancer Epidemiology presented amendments to part one of the state sanitary section… sanitary code section 1.31A, to remove the requirement that research be strictly governmental and government sponsored and to allow the research of identifiable cancer data for the surveillance or evaluation activities that are government sponsored at the federal, state, and/or provincial level when the state health commissioner determines that the proposed activity is of a significant public health importance and that the release of identifiable information is necessary for the proposed activity. The Department received one comment, one public comment from the New York State… New York City, I am sorry, Department of Mental Health and Mental Hygiene. The New York State Department of Health and Mental Hygiene was not opposed to the change, but requested that the release of identifiable cancer data for surveillance or evaluation be further broadened to included government at local levels. The proposed regulation greatly expands access to identifiable data and the Department is not

prepared to go beyond the scope of the proposed change at this time. That was the response to the City. Any questions? I'd like to see… so moved that we adopt this regulation.

[Second.]

WILIAM STRECK: There has been a motion and a second. Is there a discussion on the regulation as presented? Hearing none, those in favor, please say aye.

[Aye.]

Opposed? Thank you. The motion carries.

DR. PALMER: Thank you. The last item for adoption, amendments to sections 405.13, 405.22, 405.30, and 405.31, title X transplant services. Luckily we have our expert here on site to clarify any concerns that you might have after I read from the summary. Miss McDougal— Miss McMurdo, thank you, from the Division of Policy presented. She outlined the regulation amend section 405.13, anesthesia services, and 405.22, critical care and special care services. Adds two new sections. She stated that the proposed regulation is consistent with the Centers for Medicare and Medicaid Services and that the United Network of Organ Sharing and the United Network of Organ Sharing Policies.

The first section, 405.30, sets forth requirements for organ and vascularized composite allograph and transplant service programs. The procedures have advanced since that time. The second new section, 405.31, is related to living donor transplantation services. Current regulations only refer to living liver transplantation. The proposed regulations would expand the living donor transplantation services to all living donor transplantation services—liver, kidney, lung, and intestine—and retain some of the specialized requirements for living liver transplant. The Department convened a subcommittee of the New York State Transplant Council to assist in the development of regulations. These regulations have been published in the *State Register*. Three letters of support were received: one from the Chair of the New York State Transplant council; one from the New York Organ Donor Network; and one from the New York University Langhorne Medical Center. Miss Irving, Chief Operating Officer of the New York Organ Donor Network, a New York City-based organ procurement organization, made comments in support of the regulations, in particular the authorization and oversight of vascularized composite allograph tissues. I move that this regulation be adopted.

[Second.]

WILLIAM STRECK: There's a motion and a second on the resolution. Is there discussion? Hearing none, those in favor, please say aye.

Aye.

Opposed? The motion carries. Thank you. Does that conclude your report, Dr. Palmer?

DR. PALMER: So concluded.

WILLIAM STRECK: Thank you. Alright, we'll now move to the project review recommendations and establishment actions. Mr. Booth will serve in the absence of Mr. Kraut as the chair and so to Vice Chair Booth, I give the chair.

CHRIS BOOTH: Alright, I am gonna batch the first two companion applications. Number 141033C, New York Presbyterian Hospital/Columbia Presbyterian Center. Conflict declared by Dr. Brown, who has left the room, and Dr. Boutin-Foster who is not here. Certify a PCI-capable cardiac catheterization laboratory on site at Lawrence Hospital Center, to be jointly operated by the New York Presbyterian Hospital and Columbia Presbyterian Center. A PCI cath lab at New York Presbyterian will be decommissioned. Application 141034C, Lawrence Hospital Center.

Same conflicts as the prior application, Dr. Brown, who has left the room, and Dr. Boutin-Foster who is not here. Certify a PCI-capable cardiac catheterization laboratory on site at Lawrence Hospital Center to be jointly operated by New York Presbyterian Hospital/Columbia Presbyterian Center. Both OHSM and the Committee recommended approval of both applications with conditions and contingencies and I so move.

WILLIAM STRECK: I have a motion and a second. Is there discussion? Hearing none, those in favor, please say aye.

[Aye.]

Opposed? Thank you, the motion carries.

CHRIS BOOTH: Application 13155… 131158C, Richmond Center for Rehabilitation and Specialty Health Care. A conflict declared by Mr. Fensterman, who is leaving the room. Renovate the third floor of 75 Vanderbilt Avenue, Staten Island, to accommodate the certification of 72 behavioral-intervention, RHCF beds for a total bed count of 372. Both OHSM and the Committee recommend approval with conditions and contingencies and I so move.

[Second.]

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

[Aye.]

Opposed? Thank you. The motion carries.

CHRIS BOOTH: Application 132368C, Kendal at Ithaca. Interest declared by Mr. Booth. Construct a replacement residential health care facility within the continuing care retirement community located at 2230 North Triphammer Road, Ithaca, and add 13 new residential health care facility beds. Both OHSM and the Committee recommended approval with conditions and contingencies and I so move.

[Second.]

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

[Aye.]

Opposed? The motion carries.

CHRIS BOOTH: I am going to batch the next three issues, which were… had no recusals, interests, or issues. 132346B, Northway SPC, LLC, d/b/a/ The Northway Surgery and Pain Center. Establish a single-specialty ambulatory surgery center to provide pain management located at 1596 Route 9, Clifton Park. Both OHSM and the Committee recommended conditional and contingent approval with an expiration of the operating certificate five years from the date of its issuance. Application 141069E, Greater New York Endoscopy Surgical Center, request for indefinite life for project 062405. OHSM and the Committee recommended approval with a condition and a contingency. Application 141013E, Ralph Lauren Center for Cancer Care and Prevention. A request for indefinite life for project 062286. Both OHSM and the Committee recommended conditional and contingent approval with a three-year extension to the operating certificate from the date of the Public Health and Health Planning Council recommendation letter approval. And I move the batch.

[Second.]

WILLIAM STRECK: A motion and a second are in place. Any discussion? Hearing none, those in favor, aye.

Aye.

Opposed? Thank you. The motion carries.

CHRIS BOOTH: We have a certificate of dissolution, the Foundation for Planned Parenthood of Western New York, Inc. OHSM and the Committee recommend approval and I so move.

[Second.]

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

[Aye.]

Opposed? The motion carries.

CHRIS BOOTH: We have a re-stated certificate of incorporation, AC Center, Inc. Name change to Trillium Health, Inc. OHSM and the Committee recommend approval and I move it.

[Second.]

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

[Aye.]

Opposed? Thank you, the motion carries.

CHRIS BOOTH: We have an application for authority of the HCWNY Foundation, Inc. for fundraising. OHSM and the Committee recommend approval and I so move.

[Second.]

Moved and seconded. Those in favor, aye.

[Aye.]

Opposed. Thank you. The motion carries.

CHRIS BOOTH: I will batch a number of home health agency licensures. 2131L, Cambridge Home Care; 2135L, InterMed Health Care Services; 2132L, LK Health Care; 2365, Refuah Home Health; 1818L, Sophia's Home Care; 2209L, Magic Home Care. Both OHSM and the Committee recommend approval with a contingency and I move.

[Second.]

WILLIAM STRECK: The batch has been moved and seconded. Discussion? Hearing none, those in favor, aye.

[Aye.]

Opposed? The motion carries.

CHRIS BOOTH: Application 141004E, Garden City Surgi Center at North Shore LIJ Ventures, GSCS, LLC as a 70 percent member of the Center. A conflict declared by Mr. Fensterman who has left the room, and Mr. Kraut, who is not here. OHSM and the Committee recommend approval with a condition and contingencies and I so move.

[Second.]

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

[Aye.]

Opposed? Thank you. The motion carries.

CHRIS BOOTH: I am going to batch a number of applications here for which Mr. Fensterman has declared a conflict for each of those and he is outside of the room. 132352E, Lincoln Dialysis. Establish Lincoln Dialysis, LLC, as the new operator of Flushing Manor Dialysis Center. Both OHSM and the Committee recommend approval with conditions and contingencies.

Application 131160B, Highland View Care Center Operating Company, LLC, d/b/a Highland View Care Center. Establish and construct a 385-bed residential health care facility previously licensed as Kingsbridge Heights Rehabilitation and Care Center. Bed reduction from 400 beds. OHSM and the Committee recommend approval with conditions and contingencies.

Application 132306E, Northwoods Rehabilitation and Extended Care Facility at Moravia. Interest declared by Mr. Booth in addition to the conflict by Mr. Fensterman. Establish Northwoods Operations Associate, LLC, d/b/a/ Northwoods Rehabilitation and Nursing Center at Moravia as the operator of Northwoods Rehabilitation Extended Care Facility at Moravia. OHSM and the Committee recommend approval with conditions and contingencies.

Application 132349E, Lincoln Center for Rehabilitation and Health Care. Establish Lincoln Center for Rehabilitation and Health Care, LLC, as the operator of Dr. William O. Bennison Rehab Pavilion. OHSM and the Committee recommended approval with a condition and contingencies.

Application 132355E, Flushing Center for Rehabilitation and Health Care. Establish Flushing Center for Rehabilitation and Health Care, LLC, as the new operator of Flushing Manor Nursing Home. OHSM and the Committee recommend approval with a condition and contingencies.

Application 132360E, NNRC, LLC, d/b/a Nostrand Center for Nursing and Rehabilitation and Nursing. Establish NNRC, LLC,

d/b/a/ Nostrand Center for Nursing and Rehabilitation as the new operator of CABS Nursing Home Company. OHSM and the Committee recommend approval with a condition and contingencies.

Application 141029E, Ontario Operations Associates, LLC, d/b/a Ontario Center for Rehabilitation and Health Care. An interest declared by Mr. Booth in addition to the conflict by Mr. Fensterman. Establish Ontario Operations Associates, LLC, as the new operator of Ontario County Health Facility. OHSM and the Committee recommend approval with a condition and contingencies. And I move the batch.

[Second.]

WILLIAM STRECK: Motion and a second for the batch. Is there discussion? Mr. Hurlbut.

Did we forget one? The .

No, it’s going to come.

It’s next.

WILLIAM STRECK: Thank you for breaking this relentless march to success. We have— no, in fact, Mr. Fensterman is going to be allowed back in to vote on this last one, so that’s why we

paused. So, in the batch, before the group, there was a motion and a second. Is there further discussion? Hearing none, those in favor, aye.

[Aye.]

Opposed? Thank you. Mr. Fensterman may return.

CHRIS BOOTH: Application 132357E, URNC Operating, LLC, d/b/a Utica Rehabilitation and Nursing Center. Interest declared by Mr. Booth. Establish URNC Operating, LLC, d/b/a Utica Rehabilitation and Nursing Center as the new operator of St. Joseph Nursing Home Company of Utica. OHSM and the Committee recommend approval with a condition and contingencies and I so move.

[Second.]

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

[Aye.]

Opposed? Thank you. The motion carries.

CHRIS BOOTH: Application 141051E, Oswego Health Home Care. Interest declared by Mr. Booth. Establish Oswego Health Home Care, LLC, as the new operator of Oswego Health Home Care, Inc. OHSM and the Committee recommend approval with a condition and contingencies and I so move.

[Second.]

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

[Aye.]

Opposed? Thank you. The motion carries.

CHRIS BOOTH: Application 132124B, Union Square Surgery Center. Establish and construct a free-standing single-specialty ophthalmology ambulatory surgery center to be located at 20 West 13th Street in New York. OHSM and the Committee recommend conditional and contingent approval with an expiration of the operating certificate five years from the date of its issuance and I so move.

[Second.]

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

[Aye.]

Opposed? Thank you. The motion carries, FAINTLY.

CHRIS BOOTH: Application 141080E, Upstate Orthopedics Ambulatory Surgery Care Center. Interest declared by Mr. Booth. Request for indefinite life approval and transfer of the 13.3422 percent of membership interest to two new members. A revised operating budget has been distributed. OHSM and the Committee recommends conditional and contingent approval with a one-year extension to the operating certificate from the date of the Public Health and Health Planning Council recommendation letter approval and I so move.

[Second.]

WILLIAM STRECK: Moved and seconded. Mr. Abel, did you want to comment on this one.

CHARLIE ABEL: Yes, thank you. At the Establishment and Project Review Committee meeting three weeks ago, the Committee directed the applicant to contact the Department to discuss and develop a charity care plan. The applicant did engage the

Department and we had discussions of the charity care… a charity care plan was submitted. It appears to be acceptable. It is projecting a charity care percentage going forward of 2 percent, which is acceptable to the Department. Medicaid utilization for those members who were at the Committee meeting has been slightly below what was originally projected, but is considered to be adequate and the projections show that a continuation of provision of services to Medicaid individuals at that level. So, the Department is satisfied with the plan for charity care and obviously we will be following up with the applicant on a quarterly basis on its progress toward meeting those goals. Thank you.

WILLIAM STRECK: Thank you. Are there additional comments or questions about the recommendation? Hearing none, those in favor of the recommendation as proposed, please say aye.

[Aye.]

Opposed? Thank you. The motion carries.

CHRIS BOOTH: And the final application, 141091E, Atlantis Operating, LLC, d/b/a The Phoenix Rehab and Nursing Center. A conflict declared by Mr. Fensterman, who is leaving the room.

Establish Atlantis Operating, LLC as the new operator of Atlantis Rehabilitation and Residential Health Care Facility. OHSM and the Committee recommend approval with a condition and contingencies and I so move.

[Second.]

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

[Aye.]

Opposed? Thank you, the motion carries.

CHRIS BOOTH: That concludes our report.

WILLIAM STRECK: Thank you for your crisp elocution. You have a potential career as a BBC news reader after that presentation.

Is there other business to come before the Council? If not, you should take note of the next meetings. Next full Council meeting is August 7th; the committees meeting two weeks before. I thank everyone. This was substantial attendance on the part of the Council. Thank John's group for the work and thank all of your for your efforts today. And we are adjourned.