

NEW YORK STATE DEPARTMENT OF HEALTH
PUBLIC HEALTH AND HEALTH PLANNING COUNCIL
FULL COUNCIL MEETING
September 12, 2024 10:15 AM
EMPIRE STATE PLAZA, CONCOURSE LEVEL, MEETING ROOM 6, ALBANY
TRANSCRIPT

Mr. Kraut I am Jeff Kraut. I have the privilege to call to order the September 12th, 2024, meeting of the Public Health and Health Planning Council. We'll be joined shortly by Commissioner McDonald, participants, observers and council members. Mr. Holt had described some of the rules with regarding the webcasting. We've asked everybody for our audience to fill out the form of your attendance here. That's a requirement of Executive Law Section 166. There's papers out on the table. You may also do so online or writing directly to Ms. Leonard, who is our Executive Secretary. Today, we're going to hear under the Department of Health reports, we're going to hear from Dr. McDonald, followed by Dr. Whalen for an update on the Office of Public Health and then the Office of Aging and Long Term Care. Dr. Boufford is going to provide an update of the activities of the Public Health Committee and the Ad Hoc Committee to lead the State Health Improvement Plan, followed by Dr. Rugge with report on the health planning activities. Mr. Holt will present the regulations of the Codes Committee and then Mr. Robinson, under the category of project review recommendation, establishment actions. We'll review the CON applications that had been previously reviewed at a meeting of the EPRC. I just want to remind members that if you have any conflicts, most of our guests I think, understand how we've organized the agenda. If you've take the time to look at the agenda, if there's any applications that we've batched or you want to project moved from one category to another, please let us know before we call the EPRC Codes Committee.

Mr. Kraut I'd like now to have a motion to adopt the April 11th, 2024 meeting minutes and the June 2024 PHHPC meeting minutes.

Mr. Kraut I have a motion by Dr. Berliner.

Mr. Kraut I have a second by Dr. Kalkut.

Mr. Kraut Any corrections/notations/changes?

Mr. Kraut All those in favor of accepting those minutes say, "aye."

All Aye.

Mr. Kraut Opposed?

Mr. Kraut We accept it.

Mr. Kraut Now, it's my pleasure to hear from Dr. McDonald who's going to update the council about the department's activity since our last meeting.

Dr. McDonald Thank you very much.

Dr. McDonald Good to see everybody again today. A lot's happened since we last had a chance to visit. You know, first let me just start off with thanking, particularly for those who are the health care facilities that helped us with our Health Equity Assessment Survey we

sent out last month. This went to all Article 28 facilities that have submitted a Health Equity Impact Assessment to the department. As the surveys continue to come in until the middle of September I do you want to encourage anyone who hasn't yet had an opportunity to share their input and ideas regarding the Health Equity Impact Assessment process please let us know. Ultimately, this will assist the department in revising and streamlining the Health Equity Impact Assessment to better meet the needs of health care facilities, independent entities and community stakeholders. First topic I'd like to touch base with you is Avian Influenza. You know, the department remains vigilant about Avian Influenza, H5N1. It's been in the news recently, and I just thought I'd make sure you knew where I'm looking at this issue from. You know, part of the reason that made the news was there's a recent story about someone in Missouri regarding an H5 infection with no known animal contact. This is still being investigated. The person did recover and the final subtyping event was not completed. Not sure it will be. You know, I wonder sometimes when we talk about these H's and N's if that means anything to people. There actually is a little bit of science behind that. There's only eighteen different H's, which stands for the hemagglutinin glycoprotein. There's only eleven different N's. Those are the neuraminidase. This has a lot to do with how influenza A viruses are subtype. I do like to remove the mystery sometimes of these things. You know, we're used to H1's and H3's that cause seasonal influenza. We're used to type B's. That's what we're used to. When we talk about H5N1, I just make sure we have context about it because it is still unusual. Fourteen human cases since 2022. Of course, it's been in the news because what's been going on mostly in people who work with livestock. I do think it's important, though, just to make sure we have context about this. Although there's no known animal exposure to this individual, and I don't want to be speculating here, but I just think it's important to remember that the US Department of Agriculture tells us 201 different avian species do carry and spread H5N1. You know, birds are birds. They leave their donations all over. I'm not saying I know how this got transmitted, but I do think it's important to say, like, why did I stop what I was doing when I heard this, right? What I was concerned about was how was this discovered? When you have a positive flu test inside of a hospital where this was... You know, they do flu tests. They did say, well, is it H1 or H3? When it wasn't a routine public health activity post pandemic needs to go get this subtyping done. There's been a lot that we've learned from the pandemic. This is one of the things that was learned. It was determined that it wasn't H1/H3. They found out it was H5. This is what got everybody to really be vigilant about this. What I did with my team was I just found out what is flu doing throughout the United States right now because H5N1 has been a problem. Lot of state health departments, including ours, have been following influenza throughout the year, regular influenza. Just so you know, we don't normally follow it during the Summer because it isn't usually prevalent enough to do that. Just so you know, the week ending August 31st in New York, there were nine people admitted to a hospital with seasonal influenza. To give you a little context about that because, nine doesn't sound like a very big number. It doesn't sound like a big number because it's not a big number. But like last December 30th, when we were at our peak in New York, it was a little over 2,500 people were admitted to the hospital. It's been tracking very low in New York like we would expect. We're not seeing increases of flu in New York. There's not increases anywhere in the United States right now. I think this isolated case right now is something that people need to be vigilant about, but I don't think it's a cause for undue concern. We keep track of this. You know, with Avian Influenza, it's only been a little over five and a half months since we really started talking about there was April 1st when we started about the person in Texas who tested positive, exposed from cattle. You know, it's like there's a lot going on. The risk to humans is still very low. The commercial milk supply is still safe. We do a lot of work with the AG and Markets here in New York. Richard Ball and I talk quite a bit. Other state health departments are working with us as well as the Centers for Disease Control. I

feel like we have a lot of conversation about this. One of the strategies CDC is doing, which I thought was really positive this year is there's a recognition that there's livestock workers across the United States. Not all of them are insured for whatever reason. One of the things the CDC did was make \$5 million available to the states that had active cases among cattle to give flu vaccine to their livestock workers. If you're wondering why that strategy was done, it's because of the small but... You know, real risk of what's called a genetic admixture. In other words, if someone were to get H5N1 at the same time as seasonal flu they might create a new strain that would be unwise and dangerous, more pandemic threat. It's a low risk, but it's a nice strategy the CDC is doing. States are participating in that. New York wasn't funded for that because we don't have animals in New York that were positive. That isn't something for. New York's going to do that anyway. It was something once the Governor heard about it she authorized us to go ahead and do that. We anticipate vaccinating over 10,000 seasonal livestock workers through our partners with state funds. Whether people are insured, documented or whatever, we're going to be offering seasonal flu vaccine. I think it's a nice/positive public health intervention just to make sure we really do what we can to minimize the spread of seasonal flu. You know, just another reminder. We all know seasonal flu vaccine is important. I, as a State Health Commissioner, sometimes my job is to point out the obvious. I think this year it's more important than ever. Just encourage people to do that. You know, it's funny, when I come here, I feel like sometimes I just talk about one infectious disease and then hit to another one. I'm going to talk about MPox now because MPox is in the news too. You know, and I think sometimes when we get all these theories infectious disease about like you're wondering like, what do I need to worry about? There's MPox 1. There's 1A and 1B. We're keeping track of this for you. There's been a big outbreak in the Democratic Republic of Congo and countries nearby. There has been an MPox 1 case in Sweden and Thailand. There has not been one yet in New York or in the United States. Just to give you a reference point, part of why I'm concerned about this, as we look at the MPox cases in New York, about one out of four occur in New York. We pay very close attention to MPox in New York. Just to give a little perspective, though, we're nowhere near the number of cases we saw in 2022. Right now, we have 338 reported cases of MPox. 40 are in the rest of state outside of the city and 288 in this city, which compares to 226 in 2023. Of those, 81% were related to the city. The remainder were the rest of the state. We're seeing more cases in 2024 than we saw in 2023. You know, thus far in 2024, we've administered 3,995 doses of MPox vaccine. Of that number, 85% were administered in the city. You know, in August, we worked with the State Education Department. When I say we, I mean Dr. Heslin to allow farmers to administer the vaccine, which I think was a nice change. You know, I want to thank my division of Vaccine Excellent Team. They wrote a standing order for me. I signed the standing order last Friday that anyone who's 18 or older who would like to get a MPox vaccine, who's eligible can go to a pharmacy and do that. One of the things we're trying to do is just make sure that for the high risk population that MPox vaccine is there. I know kind of recognizing not everybody has a health care provider. Someone I can stand in that place and offer you that that intervention. I choose to do that. We are planning a webinar coming up soon for health care providers just to remind people what case finding looks like. It's going to be a brief webinar. We're paying very close attention to MPox. Right now, the threat to the United States is very low, but we take it very seriously at the New York State Department health. I'm going to switch now to talk a little bit about the various arboviruses affecting New York. I feel like when I use the word arbovirus it's probably a new term to a lot of people. Really, when you think about arboviruses these are RNA viruses spread via arthropods like mosquitoes, sand flies, midges, ticks and more. We are seeing more arboviruses. The climate has changed. This is one of the things we see. Oropouche made the news because of a case in New York and twenty cases in Florida. I think most people

have actually heard of Oropouche. I think when you hear it now, you're still like, what is he saying and why do I care? Oropouche is a virus that spread by midges mostly in Central America and South America. It's really problematic in Brazil. The cases we've seen in the United States are travel associated. We're paying close attention to it. The emerging literature on this suggests that there might be some concerns for people who are pregnant like there were in Zika. It's emerging literature. I don't have a lot of great prevalence on this here, but the CDC is paying close attention to it. We are as well. We issued a health advisory to providers last month about this. Part of it is just really recognizing this is a threat to Central and South America. It's spread by midges. These insects aren't in New York, but it's something we're paying attention to. Something that's in the news far more often, though, is Eastern Equine Encephalitis or Triple E. It's been different this year. We've had more counties affected than usual. We haven't seen a human case of Eastern Equine Encephalitis New York. In fact, we haven't had a case here since 2011. I'm very thankful for that. You know, we don't really have a treatment for this. What we do is help people as best we can in a hospital. Mortality rates are quite high. The morbidity rates are quite high. We care very deeply about prevention of Eastern Equine Encephalitis or Triple E. I want to give you a perspective on this. We have seen sixteen horses test positive for the virus. Ten different counties have been affected by this so far in New York. Even just last week, we learned about two emus from Rensselaer County that tested positive for the virus. There have been human case reported in the surrounding Northeast states Massachusetts, Vermont, New Jersey, and New Hampshire. Anyone really is susceptible to this. If you get bitten by a mosquito, I don't think most of us think much of it. Mosquitoes are just part of the nuisance of summer. I'm still very much in favor of Summer, but mosquitoes are part of it. I think we are learning more and more. We really need to look at mosquitoes a little bit differently. What are those common sense strategies we can do? Not just insect repellent, not just wearing long clothing, but just making sure there's not standing water where you're moving about. You know, just share a little anecdote with you. My neighbor, who I love dearly, is wonderful, has this tiny little portable birdbath. I just empty it every other day because I just don't need all the water near my house.

All (Laughing)

Dr. McDonald You know, my neighbor is fine with me doing that. Part of what I'm just saying is I really think we need to look at just prevention differently, right? Because once someone has Eastern Equine Encephalitis it's supportive care. Sometimes prevention is the best medicine. A lot of times I don't think we recognize that it's too late. I worry about Eastern Equine Encephalitis. I'd really like to keep no cases in New York. West Nile virus is also in the news. Again, I'm talking about arboviruses more than usual, but it's really a threat. Was just from Suffolk County just reporting three more cases and West Nile virus in Suffolk County. We're seeing double digit West Nile virus in the city and double digit West Nile virus in rest of state. That has a much lower morbidity and mortality rate. We still do want to see less cases. Again, if you protect yourself against mosquitoes, and I think this is just something we need to be thoughtful about. The climate changed. I think we need to look at ourselves as like how do we protect ourselves and just looking at not tolerating mosquito bites. I want to talk about COVID, Flu and RSV. In August, I issued a standing order for respiratory syncytial virus vaccine. We did that last year because people asked us to. We did it again this year. Again, I'm very grateful to my Division of Vaccine Excellence Team for updating it. The recommendation changed. Now, if you're 75 and older, you need to get a dose. It's just one and done right now. If you're 60 and older, it's only if you have certain qualifying medical conditions. The change was really to move away from the shared decision making model of last year to just make it more concrete. When I do standing orders really what I'm trying to do is just reduce barriers to care.

Because a lot of times what I find people say is I have to go to my doctor. The doctor would say, Well, go to the pharmacy. A order has to be transmitted. You know, when you have you have to do one thing and then another it doesn't happen sometimes for some people. I'm just trying to make this something that's easier for people. We're happy the standing order went out. In September, I issued a standing order for COVID vaccines as well. We actually did that with the Governor last Wednesday in Manhattan. She got her vaccine. Went into a CVS and got it, which I think is great. Again, I think it's important we look at why we're doing COVID vaccines. It's really to minimize people being in the hospital, minimizing the consequences of being sick and missing work and just missing life. If you do get the COVID vaccine, you do lessen your chance of getting long COVID. I think that's important information. One of the things I worry a little about is where people get their information from. If you talk to your doctor, your doctor is generally not confused about COVID vaccine. They're very familiar with what's going on there. I would encourage people to talk to the doctor about COVID vaccine if they're confused. I'm getting mine in a couple of weeks. Just very important for me to do that. I look forward to that. Right now, we're seeing the Summer surge has come down. We did have a Summer surge. It wasn't as significant as previous years. Really, now is the time to take advantage of getting your COVID, Flu and RSV vaccine. Moving to something that's not an infectious disease is hospital staffing. I think we're all very aware of the workforce shortage that's going on, not just in New York, but the entire country. I do think it's important to talk about the hospital staffing law. We've made significant progress at the New York State Department Health implementing Public Health Law 20 805-T that requires hospital to enact staffing plans. The law requires hospitals to collaborate with nurses and other team members, providing or supporting direct patient care to create and submit clinical staffing plans to the department. The responsibility is on the hospital to ensure that they have a functional clinical staffing committee and process to consider complaints and resolve them. Complaints filed with the department regarding hospitals in violation of this law have been and continue to be investigated and statements of deficiency of initiatives result. As of mid-August, the Department's Division of Hospitals and Diagnostic and Treatment Nurses received 2,653 complaints. We've resolved almost 800 of them and issued 70 statements of deficiency where they do violations of the hospital's safe staffing law. The department issued a Dear Administrative letter August 7th, reinforcing the complaint process for hospitals, the importance of collaborating with their staff as well as staffing committees. The department continues to review comments from all sides regarding the importation of the safe staffing law, and we will continue investigating complaints and working with stakeholders to ensure this law is carried out appropriately. I just want to just set some context or two. We have seen a significant rise in the need. You know, just for quite frankly, something called immediate action to protect patients in hospitals. We have seen an increase in complaints. The number of these immediate jeopardy investigations rose from 35 in the previous federal fiscal year. You know, the federal year ends October 1st. We had 35 in the previous fiscal year to 93 in the current federal fiscal year. Ends October 1st. We're a couple of weeks away. 93 and 35 are different numbers. We are definitely seeing an increase in immediate jeopardy. These are things where the department health is there. They don't leave until the problem is corrected. It's a concern. We are seeing an increase in this area. I'm very grateful to my team, the surveyors who do this work. You know, often when you're enforcing a law and carrying out what is important to protect. It's not glamorous. It's not always pleasant. It's very important work. I'm very thankful we do. Many of our team members very quietly just enforce laws without fear or favor. I'm very thankful for the work they do. I want to just touch very quickly on maternal health. There's a lot going on in maternal health that the New York State Department of Health. I sometimes think there's so much going on that really people don't have a context about what we're doing. There's three large groups right now that are doing stuff on working on

eliminating maternal mortality. In particular, the Perinatal Quality Collaborative Committee started in 2010. It's a statewide network of birthing hospitals. They seek to provide the best, safest and most equitable care for birthing people and infants in New York State. It is focused on the New York State Birth Equity Improvement Project, New York State Opiate Use Disorder in Pregnancy and Neonatal Abstinence Syndrome Project and the New York State Obstetric Hemorrhage Project. That group continues. Just you know, 97% of births occur in a hospital that is part of the Perinatal Quality Collaborative. It's voluntary, but very thankful for the hospitals that participate. Now, there's another group called the Maternal Mortality Review Board. They were launched in 2019 to examine information related to pregnancy associated deaths and issue findings and recommendations to advance the prevention of maternal mortality. There's another group called the Maternal Morbidity Mortality Advisory Committee. A lot of these have similar names. They were all started 2019. This is a different group. They review the findings of recommendations of the Maternal Mortality Review Board and identify social determinants and other known risk factors, the impact of maternal health. These three separate groups have provided a total of twenty-seven recommendations between 2019 and 2023 to improve maternal outcomes. Thus far, through the hard work of my team, which I'm very, very thankful for my team. We've implemented eighteen of these recommendations. These are significant accomplishments given how much of the work occurred during the pandemic. You know, these are sometimes changing a law, sometimes writing a regulation, sometimes just a systemic change, something that's very significant that occurs. You know, when I say occurred during the pandemic, I'm thoughtful about what Dr. Siegenthaler explained to me one day how she was stationed down the city during the pandemic, working out of a context container with an air conditioner in it. That when it rained, they had to get out of because there was a threat of getting electrocuted from lightning. Yet she's working on this while managing her role in the pandemic. There's so many stories inside the New York State Department of Health of literally heroes who did unbelievable things during their work in the pandemic and somehow did their other job at the same time. I really just can't thank them enough. Some of the recommendations there's many. One is developing a systematic approach to reduce structural racism, which includes a comprehensive curriculum for hospitals on health equity and implicit bias. This goes well beyond standalone training. Another recommendation was extending Medicaid coverage from six days to twelve months postpartum. We did that. Department has extended Medicaid coverage to twelve months postpartum, ensuring continued care of people who have given birth. Another example was expanding enhancing the state's community health worker access, which included incorporating stress free zones into a community health worker program. The department prioritized funding to expand community health worker programs so more people are pregnant and giving birth in the postpartum period of access. We've developed a cardiac bundles for hospitals to use. Just a lot going on. Just really proud of the work the department and team has done. Just one or two more things. I do want to introduce Dr. David Holtgrave to you. Dr. Holtgrave is a Senior Policy Adviser at the New York State Department of Health. I don't know if he's actually here in the room, but he comes to us from the Office of National Drug Control and Policy. He's previously worked for the Centers for Disease Control. He's previously Dean of the School of Public Health of University of Albany, has previously worked at Hopkins as a Professor. Dr. Holtgrave is a Senior Policy Adviser regarding all of our overdose work. One of the things I really saw at the department was there was so much going on in the department about overdose work I was having a hard time keeping track of it all. This old slogan about this sometimes if you old saying about Hewlett Packard. It said, if Hewlett Packard knew what Hewlett Packard knows they would be bigger than Microsoft. I kind of looked at this and said, if the New York State Department of Health knew what we know. I just needed someone to not just organize it all, but lead it. It was thrilling to find someone from the Office of National Drug

Control Policy who really recognized that work in the New York State Department Health is more fun and better than working anywhere else because it is a really good place to work. On that note, I often get asked the question about how we're doing with staffing. I don't want to discourage the question, but at some point I think it's the sixth time I've come to review. I took a hint, right? We continue to rebuild the department. I mean, it's no secret we lost a lot of people during the pandemic, but we are improving with our staffing. We're still hiring. We're now up to 5,111 full time employees. We continue to rebuild. We do have vacancies, though. We have needs for the future. I'm going to make those really clear to the Governor when the time comes. Right now, we're actively recruiting. We're definitely at pre-pandemic levels, but the work is more significant and than it's ever been. Public health is a challenge in the past. A challenge in the present. It will be a challenge in the future. I'm really thankful for the team of professionals I have at the New York State Department of Health. Nobody goes to public health for fame or fortune. They really don't. They come because they bought into the mission. I really appreciate all my team members support to the mission. Let me stop there. There was just a lot to talk about today. Let me stop for questions.

Mr. Kraut Thank you so much for that wide ranging and comprehensive discussion.

Mr. Kraut Questions for the Commissioner.

Mr. Kraut Dr. Watkins and then Dr. Kalkut.

Dr. Watkins Good afternoon, Commissioner. Thank you for your presentation. You talked about respiratory illnesses. It's upcoming for this Winter season; RSV, COVID and influenza. Just want to bring this to your attention the increase in costs for these vaccines for those who are uninsured or those who have insurance that do not pay for vaccines. We're seeing that the cost for, say, a COVID vaccine can cost anywhere up to \$200.00 a shot. For local health departments that are administering the vaccine and we're giving it away free, we'll have to turn individuals away if they don't have the coverage for those vaccines. Just want to bring your attention to the cost of vaccines.

Dr. McDonald Very, very, very good point. Thank you, Dr. Watkins, bringing that. I do want to make sure that we do have a vaccine for adults program in New York. It doesn't cover everything, but we do have money for uninsured individuals for COVID vaccine in particular. If your health department isn't taking advantage of that, let me connect you after this meeting with our division of vaccinations. Heidi Rogoff is one person. We do have some bridge access money ended, but we did find some money to offer COVID vaccine at no charge for some people. Local health departments should be able to do this. Some federally qualified health centers as well. I think to Dr. Watkins point, I think there's a really, really important point here is why is the COVID vaccine so expensive? I think that's just a philosophical question for the United States to answer. Humble opinion, it doesn't need to be that expensive.

Dr. McDonald Who has another question?

Mr. Kraut Dr. Kalkut and then Dr. Boufford.

Dr. Kalkut Dr. McDonald, Gary Kalkut from the council. Thank you for the report. I think you emphasize we really do need to remain vigilant with viral diseases. H5N1, COVID, Monkeypox, the variants and genetic variability in those are really what we fear, that they'll be more easily spread in human to human H5N1, COVID, more pathogenic or more easily

spread. Monkeypox where the the DRC clade, Clade 1 the mortality rate is 5%. We don't have that, as you point out, outside of the continent right now. The possibility of spread and remaining current and clearly surveilling what is happening, I think is a true public health imperative.

Dr. McDonald Yeah, I agree. I think it's really a priority too. Obviously, I'm very concerned about it. You know, and I think that to MPox in particular, one of things about the mode of transmission is it spread very efficiently sexually. One of things you saw the Democratic Republic of Congo was the number of children that got it, but that was really more from household exposure. You really see that path as well. I think this is one of those things where there's a lot going on in New York all the time. I remain vigilant about everything for a reason. I have a lot of good people who help me stay vigilant. Looking at Dr. Emily Lutterloh over there, our state epidemiologist. Emily sleeps well at night because she has a good team that works with her as well. This is exactly the type of thing where one of the things I took out of the pandemic. There's many lessons I've learned is just it's so important for us to be vigilant about everything that could spread a risk. I really believe it's important to plan for the probable, but prepare for the unexpected. You know, in the back of my mind was I thinking that when we did the standing water for MPox, that if it became a bigger problem, we were already there? Yeah, I was. You know, it's interesting. Other companies are looking at developing vaccines for MPox. I think that's interesting. You know, Moderna just did animal studies on their vaccine, which is interesting. It's far away that they're doing animal studies. I think you're seeing larger pharmaceutical companies recognize there's more and more threats out there. Let's mitigate them.

Dr. Boufford Thanks.

Dr. Boufford Jo Boufford.

Dr. Boufford Thank you, Commissioner, for your report.

Dr. Boufford I appreciate very much your update on maternal mortality issues and all the activities that are going on. That's been a priority for the council for a number of years. We're looking forward to an update at our October meeting of the Public Health Committee in more detail. My question really is, last year you had indicated and it relates to the workforce issues you had indicated a priority for you was looking at the challenge of scope of practice, the possibility of having more people able to do more things within the sort of frame of the legal framework. I know it was the legislative activity was not successful last year, but I was wondering what this next cycle might bring. What you're thinking is there because it was really, really an important issue you had identified.

Dr. McDonald I'm glad you asked that. Let me talk about what we're doing with workforce. I do think it's important to understand every state is struggling with workforce. We're struggling as well. One thing is for the 1115 waivers, we do have \$694 million we're doing towards encouraging people to come into the health care workforce through the Career Pathways training. There's \$48 million of that for loan repayment. Most of the money is net loan repayment. Most of the money is geared towards working with our three workforce innovation organizations to really not just give people instant health care, help them succeed through their health care education of all different health care professions. You asked about the legislative agenda. We're not getting a lot of progress with the legislature. It's certainly not for want of trying or asking nicely. We tried to get licensure compacts done. We didn't have any luck there. We tried to get medical assistance, able to get vaccine. We're the only state in the country where medical system can't give a vaccine. I

didn't hear any opposition to it. It just didn't garner attention, which concerns me deeply because it's something I still hear from federally qualified health centers. I still hear about that from pediatricians. Although, you know, we might be able to do something with medical assistance with State Ed over the Summer. I'll see. I'm worried about what we're doing with Certified Medication Aids in nursing homes. You know, thirty-seven states let a Certified Medication Aid give a medicine nursing home. In New York, we let them do in the homes for office of people with Developmental Disabilities and some other places. The nursing home operators have really told me that this would really help because there is a nursing shortage. The overarching theme I think, is this, though. Health care to me is really, really critical to just overall health and well-being. I think there's a sort of myth out there that somehow if we let someone have a bigger scope of practice it'll eat into someone else's piece of the pie. I hope it's okay to be this blunt with you. Quite frankly, the health care pie is so big no one could ever eat it. What New York needs to be doing more and more is looking at how do we let more people do what they're trained to do? You know, I'll give you an example. A dental hygienist. We're a state of twenty million people. Last time I checked, 600 million teeth. We have seven dental schools, which is more than most states. We are never going to train enough dentists. I am totally interested in what a dental hygienist could do in a federally qualified health center or other Article 28 facility. I don't know they need a dentist breathing over their neck looking at what they're doing. I think dental hygienist could do marvelous things. I would love to see New Yorkers at least get their teeth cleaned by a hygienist once a year. It's supposed to be twice. That would just do an awful lot. There's so many things we need to be doing in New York regarding health care workforce. Our reluctance to move forward in this space does have adverse health consequences. The people who typically suffer are the people who are usually the people who suffer from health disparities. It troubles me deeply.

Mr. Kraut You know, following that point. During our educational session, we had this issue came up obviously. One of the things we had discussed in passing, but probably need to revisit it instead of us sitting in this room and complaining what others are not doing. Maybe some of us have to go to the legislative hearings as as representatives of the Public Health Council to... You know, we see the stories that are in this room because of the failure of the legislature for leadership to address some of these frankly simple fixes, as you say it. Maybe we need to have a conversation how we can become a little more active and not passive and just complaining about the problem. We'll come back to that at another time. We got to hit the budget cycle correctly.

Mr. Kraut Dr. Eisenstein.

Dr. Eisenstein Good morning. Thank you for your presentations. Good to see you, Dr. McDonald. You talked about COVID and Flu vaccines. As a former Infectious Disease Specialist, my flu, I consider my life's work. It's clear to all of us, and I'm sure to your department as well that there's vaccine fatigue with COVID. I know a lot of people over the Summer had COVID and acted as if it was nothing. My question to you and for the department is, is there now that we're getting into the vaccine season and they're available. You mentioned the Governor will be getting hers. Is there going to be a promotional campaign or something to help hospitals and health departments and especially those of us with health care employees who serve the most vulnerable, who would have potentially poorer outcomes with COVID or Flu if they contracted them?

Dr. McDonald Thank you.

Dr. McDonald We have a seven digit media campaign planned for the Fall that will encourage people to get COVID vaccine, more so a Flu vaccine as well. There's also work we're doing in the division. Just to think differently about how vaccines are given. You know, it's interesting. I think sometimes we use the word vaccine hesitant as a polite phrase, but it's really not an accurate phrase, is it? Because most people aren't vaccine hesitant? They're going to get a vaccine or they're not. They've already made up their mind. I think you have to just own it, right? Yet the art of persuasion is one where it's really important to do mass media. We're going to spend money. I think sometimes we have to think differently about what we do. That's going to involve community health workers. It's going to involve working with neighborhood leaders. It's going to involve working with different communities. It's going to be about dispelling disinformation and stopping misinformation on this matter. This is just changing the way people think a little bit. One of the things we just have to own, though, is like, I've been a doctor for thirty-four plus years. I'm old. When I started giving vaccines, it was whole cell pertussis vaccine. I've been around a long time. I have the safest, most effective vaccines available. A lot of times I can give them to you for free. I still find people don't want what I have to offer. That's humbling, but yet important for us to process. The exam room is not a place for conflict, nor is it a place for arguing. Strategies that we're going to employ in the health care exam room are things we've learned about how do you do motivational interview? How do you persuade people in a kind and gentle way? Because no one likes their doctor to argue with them, yell at them. That's not what I'm asking people to do, but to think differently about how do we actually engage people in a conversation. One of the things that we know there's a fair amount of literature about though for the COVID vaccine is people do benefit if they hear a doctor strong recommendation. That's the low hanging fruit for people, quite frankly is for the doctor. I recommend you get the COVID vaccine this year. I know your health. I want you to do that. If I could simply get doctors to say that more often, it will help us. By the way, I know our numbers last year were 12.3%. Keep in mind, for vaccines for people 18 and older in New York. I only hear what people tell me. For kids, I get all the vaccine information, but we don't have legislation in New York that tells me how many adults really got a vaccine. The numbers are an undercount. People have to opt into reporting their data. That was a long answer to your question, but I appreciate where we're going with that. We're all concerned.

Dr. Soffel Good morning. Commissioner, thank you for answering one of my questions before I had a chance to ask it. I really do appreciate it because I think that staffing at the Department of Health is an ongoing concern for many of us. Thank you. My question is, I read when I was reading the department reports that came in this week, the report from the Division of Health Equity and Human Rights. I was really interested in the details around the first iteration of the health equity plan. I'm sort of curious. When you look at that health equity plan and the department... What are you going to be looking at in terms of monitoring progress? How will you personally feel like we are making progress? We have had some successes in this as that health equity plan starts to unfold?

Dr. McDonald Let me first make sure we have a common understanding of the word health equity, because I feel like a lot of times we use the word health equity. If I ask you what it means, I don't know that I'm going to hear the same thing. People value health equity, but I just want to have a common understanding. I think of the word health equity. Work of health equity is intentional, but it's a recognition not everyone has the same starting point in life nor the same advantages. Yet everyone should have a fair and just opportunity for the best health outcomes. It's a simple definition because I'm a simple person. I just like to remember things simply. What I'm looking for is a balance. We need to let people do things. I need to move away from people looking at health equity as optional.

You know, one of the things that people at the department will tell you is you often hear people use the metaphor, the lens of health equity. I really reject the metaphoric lens of health equity. I'm someone who wears glasses. You can see that. I could take them on. I can take them off. They're optional. I could live without my glasses. The metaphor we use to describe health equity is it's foundational to everything we do. We choose the metaphor a foundation, because you simply cannot have a building without a foundation. You know what happens if you build a home with a lousy foundation. It's important that we look at health equity as work not being optional, but being required. What I'm looking for is ways that we, as the New York State Department of Health can actually let health care business succeed and actually do it in a way that actually promotes health equity. Here's something that I think we don't talk often about enough. Achieving health equity actually benefits everyone, right? If everybody who was eligible for work are covered by WIC, we would all agree it would be wonderful if we didn't have child hunger. I think we would all agree to we'd love everybody to have health insurance. Everybody would benefit. Health care payers would get paid. I think we'd all agree that we want to do things that benefit everyone. I think you can do those things in a capitalistic society and everybody can get what they need, but we all benefit from that. Thank you.

Mr. Kraut Commissioner, thank you so much for the report and the Q&A afterwards.

Dr. McDonald Thank you.

Dr. McDonald I'm actually running across the hall to talk to people about early intervention right now.

Mr. Kraut Have a good time.

Dr. McDonald Thank you.

Mr. Kraut Take care of the folks that are taking care of our kids.

Mr. Kraut I'm now going to ask Dr. Whalen from the Office of Public Health to give her report.

Dr. Whalen Good morning. I'm happy to be here today to address you with updates from the Office of Public Health. We will start with an update on the Wadsworth Center. As has been reported to this group, the planned construction is a large scale effort to enhance operations and efficiencies by creation of a single site on the Harriman Campus in Albany, which will house operations that are currently scattered across five sites in the city. This will also offer the opportunity to ensure state of the art lab facilities, which are expected to serve the needs for the state for the over the next fifty years plus. Currently, the project is in the schematic design phase, which involves partial design and opportunity for revisions this year. Site planning includes surveys, utilities, hydrology and other important infrastructure reviews that are underway, and the team is in close collaboration with OGS, local and state officials regarding infrastructure. This ongoing work continues with architecture and a building design, mechanical and electrical and plumbing design and regulatory aspects, including creation of a draft Environmental Impact Statement for the purposes of a State Environmental Quality Review Act or a SEQR determination. Notice of completion and public hearing announcement will be made at the end of September 24th with a public hearing on October 2024. Finalization of the center design is expected by 2026 and construction is anticipated to be completed in 2030. The Wadsworth Center is one of six CDC selected organizations across the United States that was selected to

receive a highly competitive new cooperative agreement funding to support a state based public health laboratory bio monitoring program. This award is designed to increase capability and capacity of state public health laboratories to conduct state of the art bio monitoring science and assess exposure of concern within communities of New York State. The funding will allow better assessment of exposure to environmental concerns such as per and polyfluoroalkyl substances or PFAS, pesticides and metals in communities across New York State. The funding is for approximately \$1 million per year, which will be for the next three years, beginning in September of 2024. The Wadsworth Center is also expanding community outreach with two programs the Summer Public Health Academy, in which students learned about public health laboratory science and toured other facilities around the Capital District to discover many aspects of public health. There's also been involvement with many local high schools around the Capital Region to enable students to visit the Wadsworth Lab and learn more about public health. Hopefully, this will influence recruitment of workforce and of public health leaders for the future. The Center for Environmental Health is advancing several initiatives involving legislative or regulatory changes that will better safeguard New York residents from contaminants in their homes and in water and in the environment. Some of these include consideration of new Public Health Law 1377 to implement a proactive Lead Rental Registry in identified communities of concern to combat childhood lead poisoning, for which the center is currently working to draft regulations that are expected to require lead safety inspections of all pre 1980 multi dwelling units in communities of highest risk across the state starting in Fall 2025. Regulations are expected to be posted for public comment soon and we will continue to provide updates. The center is also working to redesign and modernize Title 10 Part 16, which is focused on ionizing radiation, which is required to incorporate and references changes to the Federal Code of Regulations. This is also expected to reflect changes in medical practice as we move from film to digital imaging, including quality insurance requirements for dental training and also raise fees to cover operating costs. These draft regulations are required to go before the Public Health and Health Planning Council and reflect important work ongoing in the center. The Center for Environmental Health has also developed templates across the system to implement inventories of lead service lines. The inventories are required to be submitted by the New York State Department of Health by October 2024 by both Environmental Protection Agency's Lead and Copper Rule and by the New York State Public Health Law Right to Know Act. These templates and accompanying guidance have been shared with local health departments and public water systems to document lead service lines an important step towards replacement of lead service lines to limit New Yorkers exposure to lead from their drinking water. Furthermore, implementation adaptations to reduce the public health risk of climate change is another important effort of the Center for Environmental Health. As part of the 2022 State of the State, Governor Hochul directed state agencies to develop a state multi-agency extreme heat action plan to coordinate interagency investments and to help mitigate community climatic impacts and prioritize assistance to disadvantaged communities that may have greater vulnerability to the effects of extreme heat. During the development of the plan, staff participated in work groups to draft recommended actions. The state will help to build resilience and adapt to extreme heat, build local capacities and support local communities in taking action. New York State will be the lead agency on eight recommended actions and another twelve actions that align with current activities that respond to the impact climate change will have on communities. The state level plan complements ongoing work by DOH staff in partnership with the New York State Association of County Health Officials to encourage local level climate and health adaptations. From the Center for Community Health, the Division of Chronic Disease Preventions Cancer Programs has developed a comprehensive and useful cancer related data and reports public website, which houses a web page which houses pertinent links in

one location. The center link is in your notes and links to cancer data visualization tools, a Cancer Statistics Dashboard and the Environmental Public Health Tracking Dashboard and Cancer Reports and plans that describe the burden of cancer in New York State, behavioral risk factors associated with cancer, cancer screening behaviors and insights into cancer survivorship. Another update from the Center for Community Health on WIC. Each month, the New York State Special Supplemental Nutrition Program for Women, Infants and Children, known as WIC, provides supplemental food, health care referral breastfeeding support and nutrition education to more than 440,000 low income pregnant breastfeeding and postpartum women, infants and children up to the age of 5 who are at nutritional risk. Since 2020, the WIC program has seen a 25% increase in caseload, which is three times the national average. Federal administrative funding in New York State has not kept pace with national inflation or the states increased participation. Without increased funding to support the workforce need at local agency levels the New York State WIC Program will likely have to implement caseload management strategies such as modifying the approved food list, shortening certification periods, decreasing retention efforts and limiting target outreach measures. The department is actively looking at strategies to mitigate impact to affected children and families. We will have a more detailed approach from the Office of Public Health Practice on the prevention agenda later in this meeting, but I will say we are finalizing the planning phase for the four cycle of the prevention agenda, which is focused on improved living, working and recreational conditions to advance health equity. The 2025 Prevention Agenda will address five key social determinants of health domains; economic stability, social and community contexts, neighborhood and built environment, health care access and quality and education access and quality. These domains cover twenty-four priorities to address health conditions, behaviors and systemic issues such as poverty, education and housing, and access to quality health care, which are crucial for reducing health disparities. The Community Health Assessment, Community Health Improvement Plan and Community Service Plan Guide have been developed. This guide provides a comprehensive overview of the New York State specific requirements for the Community Health Assessment and Improvement. It also clarifies the role of hospitals and local health departments in implementation of the 2025 to 2030 Prevention Agenda. The guide includes a detailed timeline for the submission of CHHA, CHIP's and CSP's as part of the prevention agenda. Last month, a survey was conducted to identify participants for developing action plans for the key domains. Over 200 individuals and subject matter experts have expressed interest in joining the work groups. The team is also working to create an inter-agency task force for the prevention agenda, which will enable cross-sector collaboration in the social determinants of health. The task force is expected to be established early in 2025 with meetings in the first quarter of next year. Finally, the Office of Science continues work related to opioid data in New York State, as evidenced by a recent collaboration with the Bureau of Narcotics to create a data and action brief for clinicians and others on opioid prescribing. Highlights illustrate successes in New York State, including the number of filled opioid prescriptions declined 42.1% over ten years. The number of prescribing opioid to opioid naive patients has decreased 39%. Following enactment of legislation limiting the opioid prescribing to seven day supply for acute pain, the number of episodes when opioid naive patients received more than seven day surplus has reduced 74%. This is all encouraging. Of course, all of us realize there is lots of work to continue in the opioid epidemic. Thank you.

Mr. Kraut Thanks so much, Dr. Whalen.

Mr. Kraut Are there questions?

Dr. Soffel I asked part of this in writing, but the WIC issue is very troubling because WIC is obviously an essential services for many, many people. I appreciate that it is not an entitlement program. Therefore, the funds are what the funds are. I'm interested in whether the department is sort of looking at how other states are managing the fact that demand is higher than supply, if you will, and what strategies we can help think about that would minimise the impact on people who actually require their services. I think that the potential access barriers are very, very troubling.

Dr. Whalen I agree with you. What we don't want to do is create more access barriers for people as we know that the amount of people that actually are entitled to WIC. It's only a fraction of those people that are even applying in the first place. We really want to make sure that we can do everything possible to safeguard this benefit for at risk communities. There have not been budget cuts with this, but we do recognise that additional funding is necessary. In the absence of additional funding, we're looking at opportunities to request additional funding. We're also considering requesting additional funding from New York State.

Mr. Kraut Thank you.

Mr. Kraut You know, I note that, you said the lab will be built by 2030. It's not under your control. I would strongly suggest put this on the to do list that in 2030 when that labs open, we should be holding a PHHPC meeting in the lab because people should get to see what you're building. It's going to be like nothing else this country has for a state of public health laboratory. I saw some of the early plans for it. It's real exciting. I think a third of us will have a term that will last through 2030. If I'm not here, you just have to remember. That's it. Thank you so much.

Dr. Whalen Thank you.

Mr. Kraut I'm now going to turn to Ms. Rodat to give us a report on the activities of the Office of Aging and Long Term Care.

Ms. Rodat Good morning. Thank you for the invitation to be here. My name is Carol Rodat. I'm a Special Advisor to the two year old Office of Aging and Long Term Care, which has stood up eight different centers over the last two years, which we're very proud of. Those centers housed licensure, surveillance, workforce data collection, planning, financing, the Master Plan for Aging, Home and Community Based Services Policy, and our newest center, which is the Center for Hospice and Palliative Care. I'm going to touch this morning on a few of our activities. As you know, we rotate amongst our offices. It's my turn this morning to present. I will provide several items and then if there's questions, I'll be happy to take them. We are involved at this time in ACF Modernization. I know that the Public Health and Health Planning Council does not have responsibility for the ACF licensing, but we are attempting to simplify the process so that people do not have to jump through so many hoops. That is something that we'll be finishing very shortly. We will turn to the need methodology for our ACF and our assisted living program, which is a Medicaid funding program. On a positive note, we received American Rescue Plan Act dollars that were distributed to our assisted living program, \$40 million, and another \$6 million that went to our adult health care centers, which suffered greatly through the pandemic. This was an additional 5% and the federal match that was afforded to us through the American Rescue Plan Act. With respect to hospice and palliative care, the hospice need methodology has not been redone since 1986. I don't know how many people in this room were working in health in 1986, because that was a long time ago. We have thirty-nine

active licensed hospices certified in this state. We have one available for every county. However, the need methodology is very outdated, as you may know. We intended to update it in 2020 and the pandemic hit. The old need methodology is built off of cancer rates predominantly as well as some other calculations. What we have been doing is we've been developing an approach that we will be bringing to you is to look closely at the use rates in our state, the use rates nationally as well as the demographics. We will be back to you with a discussion about a need methodology in the coming months. We have also been focusing on provider education as well as our own staff education. This is deemed to be important because there has been such a turnover in facilities that we oversee the nursing homes, the ACF's, the home care agencies, the hospices. There's a lot of very new administrators, new CFO's, new CO's we see all the time. Our Center for Surveillance, Residential Surveillance has been doing monthly seminars and we post them online. We are working with providers as well as the Federal QIO Quality Information Organization to develop these educations. We recently did infection control. Yesterday, we did psychotropic medication training for nursing homes. This is a collaborative between the industry and our other state agencies. The other thing that we're very proud of is we have a responsibility to implement a new requirement in Public Health Law to afford new rights to the residents of nursing homes and ACS, with respect to the resident's actual or perceived sexual orientation, gender, gender identity and the expression of their identity. We have developed trainings for direct care workers in those facilities so that these workers have the cultural competency and preparation to deal with the changing environments, changing populations, and to provide those residents with the respect that they deserve. This education will also be posted widely on our New York Learns Public Health Learning Management System. Last, I would like to just turn to the Most Integrated Setting Coordinating Council, which is a multi state agency council on which our Center for Home and Community based Service Director sits. That council met this week. They are responsible for updating our plan, which will provide for a long range plan for those with intellectual, physical, developmental and mental health disabilities to be cared for in the most integrated settings. Thank you all for your support. I'm happy to take any questions.

Mr. Kraut Thank you so much.

Mr. Kraut Are there questions?

Mr. Kraut I have one. Just with respect to the hospice need methodology, when do you think that will be available? Because we are getting a lot of requests from providers to expand into service areas. I suspect that's a major part of thinking as an aging population we want to be responsive to.

Ms. Rodat I don't want to put an actual timeline on it, I will tell you that there is a draft.

Mr. Kraut There is a draft.

Ms. Rodat We are working with people throughout the department on that draft to review and give comments and input before we bring it back to the Code's Committee.

Mr. Kraut I would just encourage.

Ms. Rodat We are working as fast as we can.

Mr. Kraut We will put that on our watch list as well.

Mr. Kraut Dr. Soffel.

Dr. Soffel I know that New York's utilization of hospice services is very, very low, and that's a concern. Will the needs methodology in any way sort of grapple with that issue and try to address why utilization is so low and how to increase interest and engagement with hospice?

Ms. Rodat Thank you for that question because a need methodology alone will not address low utilization. When we bring it forward, this is one of the reasons we have not come forward to you is it will be accompanied by a public education campaign as well. That we will be rolling out with the support of the administration. Denise, there are many, many reasons for the low utilization. There are workforce challenges in the hospice area. There is also a lot of research on this which I can make available to people. We are a very diverse population in New York. We have to recognize that diversity when we think about end of life care. In the Center for Hospice and Palliative Care, we tend to view hospice and palliative care within the larger framework of end of life and planning for end of life, including medical orders for life sustaining treatment, advanced directives, and as well as public education. We will be doing outreach to providers in all areas of our health care system as well as the public. Thank you for that.

Mr. Kraut Yeah, the cultural differences and accepting end of life care varies widely within New York.

Ms. Monroe We're seeing more and more interest on the part of private equity to look at places to invest money that I never thought they would be interested in; nursing homes, assisted living, hospice. Is anything in what you're developing looking at expectations of ownership? What is expected in order to qualify as an owner of these facilities? Is that part of your review in terms of the regulation development?

Ms. Rodat It is always part of our review because new hospices would have to come before this committee, its establishment. We would do character and competence and financial feasibility as well as need. That will be part of the overall hospice process. As to the larger question of public equity, I'm sure that the council is aware the public equity is very active in the health care area. I'm sure that that's something you've discussed as you move through your agenda and the items.

Mr. Kraut Thank you.

Ms. Mazzacco No one's more excited about the new office of Hospice and Palliative Care. It's long overdue. Congratulations for establishing that. I'm glad that your approach is multifaceted because CON won't do it alone. Need methodology won't do it alone. I'm wondering if there's thought to support for existing hospices in the plan related to hospice utilization.

Ms. Rodat In terms of the plan for public education, we will be joining with the existing hospices to tailor those education efforts locally. One of the reasons we're doing that is that as we talk to the hospices around the state, we've learned that the Medicare reimbursement, which is roughly 95%, at least of their reimbursement and does not adequately always recognize the labor costs. You would be one who would know that as well as anyone. One of the things we need to do as they've cut out their marketing and their outreach activities is work with them locally to tailor those education sessions and that outreach.

Ms. Mazzacco Thank you.

Ms. Mazzacco If I could ask a follow up question.

Ms. Mazzacco I'm curious about any items that you're looking into related to certified home health agencies and the closures that we're continually seeing, especially upstate, that are impacting access and then in turn impact hospitals and ER's.

Ms. Rodat Thank you.

Ms. Rodat I'm seated next to the director of Home and Community based Services Licensure. We both track this on a regular basis. Yes, we are seeing closures. Again, one of the issues is the reimbursement rate of Medicare and Medicare Advantage. Both the traditional Medicare and the recognition of the labor costs do not fully recognize the cost that you have to pay for a nurse because you absolutely have to have an RN working in both of those agency types. The other thing that we are seeing with respect to certified home health agencies is that they are having a very, very difficult time recruiting and retaining their staff. We will see consolidation, continued consolidation and likely more closures as we move forward. Again, the Medicare reimbursement plays a very important role in the capacity of these agencies in the state of New York. That has to do with the labor component.

Mr. Kraut Thank you so much.

Ms. Rodat Thank you.

Mr. Kraut We look forward to continuing the conversation, obviously, on hospice care and the need methodology.

Mr. Kraut I'm now extraordinarily pleased to introduce Dr. Boufford, the Public Health Committee, the Codes Committee and the EPRC. We are all going to have to take votes on specific resolutions. Just to have your attention, focus.

Mr. Kraut Dr. Boufford is going to present a report on the activities of the Public Health Committee. We're going to review a plan on the prevention agenda.

Dr. Boufford Thanks, Jeff.

Dr. Boufford Good morning, everybody. I want to provide some background to tell you why you have a resolution on the table the council will be voting on shortly. First, let me acknowledge and welcome Dr. Whalen. She's been a terrific partner. Even though she's just been here since the end of June, she's really kind of bring this to the finish line. I appreciate her efforts and Zahra ALaali, her colleague in this work. I was looking back in the minutes of the council. Over the last, I think eighteen months, from time to time, we've been telling you what was going on. I just want to thank the Public Health Committee members for their resilience and strength and going through many, many meetings over the last eighteen months, really to look at the proposed change of the prevention agenda, fairly considerable change from focusing on sort of five major causes of premature morbidity and mortality in the state over the last... Really, the last ten or twelve years. This is the fourth iteration to moving towards a broader consideration of social determinants of health, which is where public health is going. I think really speaks to the context in which

people live and the need to bring the clinical enterprise and the broader population health focused enterprise together. The Public Health Committee, at the last June meeting of this council. Again, this council has statutory responsibility for approving the prevention agenda because it is the State Health Improvement Plan which is required both in state law. You're going to see a little bit about that and also in federal law for hospitals. In the June meeting, because of the multiple meetings we've had, which were, I think, really, really important with collaborating state agencies, with the hospital associations, with the New York State Association of Health Commissioners and many other stakeholders over the last eighteen months to get to ask them to look back on the previous design and structure of the prevention agenda and to consider proposals from the department to change that and to make recommendations and then eventually provide their statements of support. This has been done not only through the Public Health Council, but all through through the Ad Hoc Committee for the Prevention Agenda, which is sort of from the accreditation of the state process, the sort of public community engagement body. That consists of people who are leading state level organizations, state level nonprofits, advocacy groups, professional associations and others. I think we've had thirty to forty of those folks around the table in these meetings, again, several of these meetings over the last eighteen months to take a look at the proposed changes. In the June meeting, the Chair and the council agreed to delegate authority to approve the revision of the prevention agenda going forward to the Public Health Committee, basically so as we would not lose time in issuing guidance, we were behind, a little bit behind schedule of issuing guidance and to be able to move that, but with the condition that we would bring it to you. We wanted to pull it all together today and to give you a summary. There's a slide set that has been prepared. I think it's at the table in the hard copy and will be presented by Zahra. I'm sure Dr. Whalen will have some introductory comments. Just to frame the resolution that you have in front of you. It reflects the essence of the Public Health Committee's sort of concerns that have been raised largely around the question of asking for more specificity on implementation and also asking for more clarity on leverage and impact, especially the leverage and impact that the Health Department would exercise and should exercise can exercise going forward to look at leveraging the work of other agencies to address the social determinants of health. I'll come back in more specificity when we actually move the resolution. It's in three parts. The first sentence really talks about the framework for the prevention agenda. It really establishes twenty-four priority actions for state health departments, hopefully in collaboration with hospitals. The plan is for those actions. You'll hear the implementation part of it, but those actions would then be presented, referred to the state. They would be proposed to the state and the state would oversee the the implementation over the next cycle of the prevention agenda. The second areas of the resolution refers specifically to the determinants of health and speaks to the creation of an interagency.

Dr. Boufford Well, we need the resolution because I think people need to know what they're voting on.

Mr. Kraut We're the only two people who have it.

Dr. Boufford That's not useful. I didn't know that. Sorry about that, folks.

Dr. Boufford Can we do a slide share in the moment, perhaps a screen share of the document when we get back to it?

Mr. Kraut Shared on the screen, please.

Dr. Boufford I think the presentation will inform you, but let me just say on the resolution that you will see either on this screen or when it's distributed is essentially in three parts. One is to cover the actions of local health departments in hospitals, and they're reporting to the state health department for twenty-four priority objectives that have been developed. The second part of it is the commitment of the state health department as it will need to do really working with other agencies to mobilize their engagement to move on the social determinants of health. The third part is to increase the alignment of hospitals, community benefit investments with the priority areas of the prevention agenda. We'll come back to those. You're going to hear background on all three of those in the slide presentation. We'll come back to the resolution when we either have the copies or we're able to share it with you before there's a vote.

Dr. Boufford I'll turn the mic over to Dr. Whalen and she'll I'm sure have some introductory comments and then we'll hear the presentation of the slides set, which I think you do have at your place and will be put on the screen. Sorry for that problem and we'll make it up before we get to it. Thank you.

Dr. Whalen Thank you very much, Dr. Boufford, for your gracious comments and for your ongoing assistance and collaboration on this very important work.

Dr. Whalen Is that better?

Dr. Whalen I apologize. I usually have a pretty good theater voice, but I guess it's quiet now.

Dr. Whalen Yes, we are very pleased to present to you the vision for the prevention agenda, the 2025-2030 state improvement plan, health improvement plan. This has been the result of a lot of work and a lot of collaboration, which we will lay out for you. I think, you know, as Dr. Boufford said, the most important thing is to really look at how we are addressing a framework that supports the social determinants of health, really addressing the root cause of chronic disease and addressing considerations within communities that we know impact health and population, health and public health.

Mr. Kraut Could I have the slides projected, please, on the screen? They were up there a second ago and now they're gone.

Mr. Kraut Thank you.

Dr. Whalen With that, I'm going to turn it to Zahra ALaali, who is the Prevention Agenda Coordinator to provide information on the slides.

Ms. Alaali Thank you, Dr. Whalen.

Ms. Alaali If you look at the first slide here on the screen, you can see or in the copy you have you can see the planning and implementation timeline for the new new cycle of the agenda for 2025-2030. The process started in March 2023 with partner engagement and the formation of the Ad Hoc Committee. The planning team then collected data for the State Health Assessment and gathered partner feedback on health challenges over the eighteen months or over the last eighteen months. This collaborative effort led to the identification of forty-four health issues and challenges, including health conditions, behaviors and social determinants of health. Then a prioritization tool was used to rank these issues and it was sent to different stakeholders and partners, resulting in a new

prevention agenda framework with twenty-four priorities for the 2025-2030 cycle. Currently, we are working on forming working groups to develop the action plans. Dr. Whalen already mentioned that the survey has been distributed. We have over 200 participants who are interested to be part of this working group. Once these plans are finalized, the implementation of the prevention agenda is set to begin in January 2025. Our team collected data in several ways. Several data sources were used for the State Health Assessment, including in New York State data profiles. There is different examples here in this slide. We also reviewed and analyzed the local health departments and hospital assessment and plans, the changes and CSPs. We collected input from different partners and our stakeholders . You can see here a list of the partners and stakeholder we worked with. The Ad Hoc Committee is consisting of over 120 representative from New York State Department of Health Staff and forty-eight agencies across various sector. For example, we have local health departments at the table in New York State Association County of Health Official. We also worked with hospitals and hospital association. We worked closely with other state agencies such as Department of State, Office of Mental Health, New York State Office of Addiction Services and Support, among others, and also local agencies and community based organization. Over the last eighteen months of extensive assessment, data analysis and input from key partners. We identified a range of issues from socioeconomic factors to specific health conditions. In this slide you can see that we grouped them into six themes. Number one is economic well-being. Number two is mental wellbeing and substance use. Number three, safe and healthy communities. Three, maternal and child health. Four, health care insurance coverage and access to care. Last is education, access and quality. The social determinants of health factors were also recognised as a key area requiring attention in New York. To address this, we recommended the integration of social determinants of health into the new prevention agenda for the next cycle. This integration will address direct and indirect factors, influence in health and to reflect also the needs for the community by integrating the social determinants of health. The new prevention agenda will be more consistent with the national initiative such as Healthy People 2030. As you may know, the Healthy People 2030 is data driven initiative that provides evidence based interventions and resources to help addressing public health priorities. There is existing interventions for those social determinants of health.

Dr. Boufford I think we have the slides. Maybe you can hit the high notes of each of the slides so that we can get through the important presentation so people can consider the resolution.

Ms. Alaali You can see the different structure or different priorities for the new prevention agenda. On the left, we have the 2019- 2024, which has five major priorities, including prevent chronic diseases among others. On the right, you can see the new prevention agenda and the five social determinants of health from Healthy People 2030. By addressing social determinants of health, we can basically address systematic root of causes or causes of disparities, which has been increasingly recognized. When our team did the assessment, for example, we identify that the rank of New York State has dropped from 11th in 2019 to 23rd in 2022. Much of this decline stems from the latest ranking algorithms, which include social and economic factors that public health has largely not focused on. This new framework targets the root causes of health inequities leading to more effective and equitable health outcomes, which will accelerate progress toward health equity. It is also more aligned with the new vision of the New York State Department of Health, which focus on health equity. Moving to the new Prevention Agenda framework. If you look at the top here, we have the new vision of the prevention agenda would shift the focus from being the healthiest states in the nation to focus more on being the to focus

more on achieving health equity. You can see the foundations. For the next cycle, we will continue with these four foundations; health equity, which focus on addressing social determinants of health and reducing health disparities. The second foundation is prevention across the lifespan, which focus or advocate for increased investment in primary and secondary prevention at every stage of life. The third principle is health across all policies, which promotes interdisciplinary multisector collaboration. For example, currently we are working with the Office of New York State Office of Aging to align the prevention agenda with the Master Plan of Aging. The last foundation here is local collaboration building, which promotes community engagement and cross-sector collaboration in local planning. As I mentioned, we will continue maximising the impact with evidence based intervention for state and local action. For the Prevention Agenda framework structure, the new framework is streamlined. There are twenty-four priorities involved. You can see the social determinants of health domains from Healthy People 2030. On the right side, the priorities are the one in blue. The purple one is just the themes. There are some priorities that carried out from previous cycles, such as mental well-being and substance use disorder, tobacco and e-cigarette use. However, there is a new priorities such as economic well-being and education, access and quality. The New York State Department of Health for the action plan they will provide an overarching goal for each domain. We will also provide the following for each priority area. We will have one, two, three objectives for each of the priorities. We will have a main indicator to track the progress. We will also provide evidence based interventions. If evidence based interventions are not available, then we will provide promising practices and best practices. As mentioned by Dr. Whalen, currently we are establishing the working groups and the working groups will be working starting, I believe, end of September until mid October. We will have five working groups representing each domain. Currently, we are creating some tool kits and training materials to guide the working group when they start creating those action plans. For the next cycle, we are shifting from smart objectives to smart objective. SMART is an acronym for specific, measurable, attainable, relevant, time based. We are including two new items. One is inclusive and equitable to make sure that the objectives are inclusive and equitable. For the implementation of the prevention agenda, the prevention agenda is designed to be implemented by a wide range of public and private partners. Hospitals and local health departments or leaders in local community health improvement planning. However, the list of priorities, objectives and evidence based interventions and strategies and the prevention agenda can provide flexible options for other partners, whether state or private or other type of organisation to implement and adopt. Given the complexity of the identified health priorities or priorities in general and the prevention agenda, cross-sector collaboration is always a key. There are several ways to support the prevention agenda efforts in addressing social determinants of health. One of them is the local health department and hospital local community health improvement planning. We are talking about the Community Health Assessment, Community Health Improvement Plan and the Community Service plan submitted by local health departments and hospital. The second channel is the Certificate of Need. In New York State health care facilities are required to submit a Health Equity Impact Assessment and also they are required to report activities that advance prevention agenda goals with the Certificate of Need Application. These certificate of need requirements ensure the facility as a proposed project aligns with the prevention agenda and enhance health equity. For the next cycle, we are looking for opportunities to strengthen collaboration between local health departments and hospitals. We are looking also for opportunities to ensure a stronger alignment of hospital community investment with local health departments priorities. Lastly, we are looking to establish cross-sector partnership. You can see the main differences between the current cycle of 2019-2024 and 2025-2030, which is the new cycle. Both of them are six years cycle. In 2019, the focus was major public health areas with a focus on

addressing disparities and promoting health equity. The new cycle focused more on health equity and incorporating social determinants of health. I already mentioned that we're switching from smart objectives to smarty objectives to have inclusive and equitable objectives. Submission of the community health improvement plans, assessments and CSB's. In the current cycle, how hospitals and local health departments, they have a submission they submit every three years. However, for the next cycle we will shift or local health departments will shift to six years submission cycle and hospital will continue with three years submission to meet the federal requirements of being exempted from taxes. For variety selection, the current cycle, local health departments basically, and hospitals are instructed to select two priorities with one focus area or two priorities. They must address disparities and promote health equity. However, for the next cycle, they can select three priorities under one or more of the domains. Basically, the community health assessment is the main guide for their community health improvement plan and the selection of the priorities. We basically created the guide. We explained the role of hospitals and local health departments,. We encouraged the collaboration through all the phases of assessment and implementation. We encouraged the submission of a joint plan. A joint plan mean that the hospital and counties were basically submit one plan for their assessment and their implementation. We continued doing this in the next cycle as well. Last year for collaboration, interagency collaboration, the current cycle we have the Ad Hoc Committee, which is an interagency working group. They have been involved during the planning of the prevention agenda. This continued also for the new cycle of 2025-2030. However, for the new cycle, we are aiming to develop an interagency working group to add to social determinants of health. The Interagency Working Group basically will provide a forum or a government culture that prioritize health and equity across New York. It will provide also a forum for opportunities and collective resources. Currently, we're exploring opportunities for existing interagency counsel to create a working group to perform this function. You can see the timeline. By October 2024, we will define the mission roles and responsibilities for the working group. By January 2025, we will start recruiting members. March 2025, we will hold the initial meeting to introduce member outline objectives and review the Prevention Agenda framework. After the initial meeting, the working group will start quarterly meeting to review progress against the prevention agenda. I hope this was short and sweet here.

Dr. Boufford A lot of important information. I think we heard pieces of it certainly. Remember, many members of the council have been attending the Public Health Committee meetings, which we appreciate having the background. I was just consulting with Jeff. I think what I'd like to do is make the motion, put the motion on the table to have it hopefully seconded and then have discussion/questions relative to that before the vote.

Dr. Boufford Does that make sense to everyone?

Dr. Boufford Everybody, I think, has a copy of the motion now. Again, I think this was an effort to really reflect the really important contributions. I think in conversations of the Public Health Committee and the Ad Hoc Committee over the last month to move towards something that was the implementation strategy was made much clearer, which we really appreciate, and the issues of accountability and leverage, I think we feel the options are there, the potential is there and that would be essentially what the council would be tracking over the next while. Two other comments. We do have a Public Health Committee meeting in October. We'll have another one in December to sort of track the way towards the end of this calendar year. We'll have another Ad Hoc Committee in December. That gives us a period of time not only to hear more about what the working groups under each domain will be doing, but to assure the linkage is certainly with at least the prevention

areas of the Master Plan on Aging and also Dr. Whalen's mentioned the issues of of linking up this process to the waiver activities. I think those are two things that will go on during this this next period of time. Again, now that you have it in front of you, I think easier to think about in terms of three sets of activities. The first one, I'll read it on the PHHPC approves the proposed framework for the Prevention Agenda 2025-2030 that establishes the priorities for state and local action in New York State to help achieve the vision that every individual in New York State has the opportunity, regardless of background or circumstances, to attain their highest level of health across the lifespan. That reflects the vision and goal of the Department of Health. That extra language, the idea, the important action step here is we approve the framework which you saw. Twenty-four priority areas are identified through the data gathering. The second area is the council agrees to the new focus of the plan on Social Determinants of Health and the department's commitment to engage additional state agencies to support advances in improving economic stability, social and community context, neighborhood and built environment, health care access and quality and education, access and quality. Those are the social determinants of health that are listed. Slide 10 is the money slide for those of you that want to pull it all together, but those will be necessary. Obviously, issues of housing, transportation, air quality and other are not under the direct remit of the Health Department but are under the responsibility of other departments. It will be very exciting to see them directly engaged in this process. The third set of activities. The council also supports efforts to promote alignment of the hospital community benefit investments with the priorities of the prevention agenda. I want to pause here for a moment. We did discuss the community benefit requirements on hospitals in New York. It is really essentially to meet the requirements of every three years doing a community needs assessment State Health Improvement Plan. It has been a voluntary process. There has been discussion going back and forth about whether we wanted to tighten the statutory language that would really direct I wish I would say local health departments and hospitals to work together and share not only the needs assessment, but also the plan. The decision at this stage was to maintain the voluntary effort. I only flag it because I think New York does very well when we highlight the importance of voluntary efforts that might end up in having something that becomes less than voluntary. We've had a lot of discussion, I know within the departments met with HANYS Greater New York. Progress has been made. About 45% of counties have historically been doing this work together. We hope to get that number up over the next, especially the next couple of years. The Public Health Committee of the council and the council commit to a regular review of their progress during the next six years to support its successful implementation. As I mentioned, the Public Health Committee will meet twice between now and the end of the calendar year. Ad Hoc Committee in December. We should have good reports on the progress. We'll begin to track the timetable for the interagency work and for addressing and discussing the community benefit work. I will move the resolution.

Dr. Boufford Dr. Berliner has his name up fast.

Dr. Boufford Open the floor for questions to Dr. Whalen, Ms. ALaali, myself or others about the presentation and or the resolution.

Mr. Kraut Dr. Eisenstein.

Dr. Eisenstein Thank you.

Dr. Eisenstein Larry Eisenstein, council Member. Thank you both for the great presentation. Dr. Boufford, since our last committee meeting, we've actually gotten great

clarification regarding the Medicaid waiver, which I know you mentioned. In that New York State prescribed the specific screening tool of social determinants of health that providers, community based organizations, hospitals would all have to use in order to participate in bill and the waiver. The question that I have it's more of a plea. We are supportive of work in line with social determinants of health, but it really needs to be aligned with the other initiatives that are happening. It's a lot of work to change an electronic health record to meet the new requirements. I think that we're doing that now. We don't want to have to do it again because it costs a fortune, which hurts our ability to provide services and takes a very long time, which back this up. Has there been thought to how you're going to align the various emerging requirements of social determinants of health, which are both at the state and federal levels, as well as making sure that the data collection is streamlined? We could have parallel, but we certainly don't want conflicting data collection is my point.

Dr. Boufford Well, I think one of the these social determinants here are the ones that are reflected in the federal Healthy People process. They've been vetted for an evidence base. I think they're the same ones that CMS is including. They may not be exactly the same because the bar for evidence is the same within the department. Those questions on social determinants are pretty aligned, but when they're not---

Mr. Kraut Can I just amplify on your question?

Mr. Kraut There's no mention of the SCN's in here.

Mr. Kraut You talk about hospitals and holding them accountable. We're spending \$7 billion. I think that's the point you're making is how are they going to be held accountable for their performance in attaining these goals? Look, it's something I think you said in passing. You're going to have to come back. They're still evolving. They're not all formed yet.

Dr. Whalen I think that this is going to be a key driver of the work of the interagency task force. We really want to ensure that there is cross-sector collaboration on the multi, the myriad of agencies that are working towards addressing social determinants of health, including the infrastructure, the development of the social care network that is being established. I honestly think that the timeline is right. They're kind of in their planning process. We're in our planning process. It would be great if we can work together to ensure that there is this cross-sector collaboration that makes things move forward with more efficiency.

Dr. Boufford Let me also comment because I think I've said this before. I think the SCN's are social care networks services, health and social services. The prevention agenda has historically been population health focus, not care focused. I think the idea here of linking with social determinants is that the context of communities would hopefully be affected by interagency work, especially by the prevention agenda. There's a health care access and quality element here. That would be this place in which the care efforts need to be aligned. The state efforts on the care side need to be allied. The only other thing is that the prevention agenda is the State Health Improvement Plan. The only language in the State Health Improvement Plan affects hospitals.

Dr. Eisenstein Regarding the timeline, but just so the states where as the social care networks have been named. They've already told their providers, hospitals, doctors, community based organizations what tools and electronics they need to set up. We're already working on that. The collaboration would have to happen really soon before we,

the whole health care community invest the time and effort to change how we're collecting social determinant data. We just hope it doesn't happen again in the near future because that will just set everybody back again is my point.

Mr. Lawrence Harvey Lawrence, a member of the council. I'd like to again congratulate you, Dr. Boufford, and the committee, and which I have not been fully participant participating in. It is great to see that this work is continuing. I'm wondering if you're accepting wordsmithing on the motion.

Mr. Kraut We prefer not to.

Dr. Boufford I think if it's substantive, probably that it requires a bigger debate.

Mr. Kraut This took a lot of effort to get it on this piece of paper, to get it in front of us.

Dr. Boufford It's fairly high level.

Mr. Kraut Unless you think there's something substantive.

Mr. Lawrence I'll throw it out there, and, you know, if you think it merits a change. If not, it'll be fine. Just down where you say their highest level of health. I would say the highest level of health. Because in my view of the world, when you say there it sort of comes with limitations, especially when you're talking about social determinants of health. If I'm living in an underserved community and there are some constraints about reaching that highest level of health, then it's sort of accepting circumstances in which the person may find himself. The other comment that I would add would be to the department's commitment of health equity, because that has been something that has been discussed here, I think, over the last year or two. There should be some reference to this notion of health equity, which would go right after the department's commitment to health equity to engage additional continuing. Those were the two changes that I think would make a difference.

Dr. Boufford I think adding the equity around the broader determinants of health makes a lot of sense. I would think that would be a good suggestion, assuming Dr. Berliner agrees. I mean, most of my times this point is spent in dealing with issues of global health and the way this language is used. It's I appreciate your picking up on it. The reason the word their highest level of health is in that context is that people have different levels of disability range and they have different levels of sort of biological endowment. The reason that there is there is the obligation of the state of government is to provide the environment in which they can reach the highest levels of their ability of health as opposed to an abstract concept.

Mr. Lawrence I guess the way I'm looking at it is that sometimes when those disabilities are disclosed that the provider begins at that becomes the baseline, as opposed to looking at the possibility that the person can in fact have a greater level of outcomes than what is stated by the circumstances that they find themselves in.

Dr. Boufford This is the line we're walking here getting involved in the health care delivery system in the clinical enterprise, rather than purely trying to deal with improving conditions in communities which... You know, the sort of discussion, the link point is you have a patient coming into your office and has to deal with many of the issues you describe. You send them back to the same environment that made them sick in the first place. Part of the prevention agenda focus historically is improving that broader environment. I think the

details of the presentation and sort of the slide, I think we should add the equity thing for sure. With your agreement, perhaps we can understand that it's embedded in the guidance. You'll be at the meeting. You can help us track that question as to whether we do it or not.

Ms. Monroe Thank you.

Ms. Monroe I have one quick question and then a comment. You say that a local health department only has to resubmit after six years. During those six years, there's reporting on progress, right? They only have to submit their new plan or whatever you call it. There's accountability across those six years. Who sets those standards for achievement the local health department or the state?

Ms. Alaali For the reporting, there was an annual report and there is also a mid-cycle reassessment to refresh their data and make sure their prioritization are still priorities for the county. This will make sure that there is an alignment between the priorities of the health department and hospitals since hospitals are submitting every three years.

Ms. Monroe The second point that to me there's a big difference with the health department between the health department calling in all the other departments to help the health department achieve social determinants of health. There's a difference between that and every department being accountable for its piece of social determinants of life, whether that's education, economic stability. I worry about a task force that is convened by the Health Department in which other departments are told to help us as opposed to some higher group; the Governor, the directors, council, whatever you call it, saying to each of these departments, here is what you are responsible for achieving. I've always thought of these as social determinants of life and not totally health centered. I do worry about the commitment of other departments with everything else they have to do to achieving our goals. Is there any comment on that?

Dr. Whalen I want to thank you for that feedback. I think it's very important feedback and certainly something that we're considering. We want to be good stewards of time, of leadership of other agencies. We are not thinking of calling this group together to help the health department, but really to look at where opportunities exist for collective impact. We are looking at where do we have shared mission, shared values and shared plans to implement policy procedure programs that are going to achieve goals that are related to the social determinants of health. I agree with you entirely that these are aligned with the work that many other agencies are doing. It's not necessarily asking them to do anything above and beyond what they're doing. It's how can we work together to amplify the work that we're doing separately? How can we work together to create synergies?

Ms. Monroe I appreciate that. I would just add, there needs to be some accountability for those departments to do what they commit to do, especially if that's not high on their priority list.

Dr. Boufford It's a good point. I think that's part of what we can engage on relative to the launch, the preparation for the interagency council and launch the really important questions for that stage of the work.

Dr. Soffel Yeah, I did participate in a lot of these committee meetings. There was a lot of conversation amongst the committee members about the importance of engaging communities and having community based partners and community based organizations

and community involvement in this process. I don't really see that reflected much in this document. There's one brief mention of private public collaborations. It's not in the resolution at all that community involvement is essential to make this a successful endeavor. I'm not going to fail as we write the resolution, Dr. Boufford. I am going to say let's make sure that as we as a committee watch this over the next six years, that we continue to push the department to push the local departments of health to be sure that they are in fact, not just with their hospital partners, but with other community partners as well.

Dr. Whalen Thank you for that.

Dr. Whalen I can say in my own experience as a local Public Health Commissioner that this work does not get done without community based organizations. The work of local health departments is intimately related to the work of the community based organizations that they share territory with your community with. This happens not only within the prevention agenda, but across all programs and services.

Dr. Boufford I think one of the follow up in this sort of in the reporting process historically, we actually asked who's at the table. We've asked local health authorities to include that. Who's involved in these conversations? It's an easy question. They've not had too much difficulty answering it. I think, again, that's another way in which we can look at this over the next while.

Dr. Boufford Anybody else with questions?

Dr. Boufford The council agrees to the new focus of the plan on the social determinants of health and health equity and the department's commitment. Does that work for you?

Dr. Boufford We'll change the language.

Dr. Boufford The second sentence starts, "The council agree to the new focus of plan on social determinants of health and health equity and the department's commitment to engage. Does that work for everybody? That's the only change to the resolution.

Dr. Boufford Back over to the Chair.

Dr. Boufford You've now heard the resolution.

Mr. Kraut Dr. Berliner amended his motion.

Mr. Kraut I have a second, just to be sure.

Mr. Kraut I'll call for a vote to adopt the resolution as just presented.

Mr. Kraut All those in favor?

All Aye.

Mr. Kraut Opposed?

Mr. Kraut The motion carries.

Dr. Boufford Thank you very, very much.

Mr. Kraut I really have to take a moment and thank Dr. Boufford, the committee, the Office of Public Health, the other members of the Department of Health who have worked on this. This is not an easy task. This is a real challenge. It's a critical part of you've heard the regulatory requirements, the accreditation of the department is dependent on this. It took a lot of meetings. There was a lot of effort that went into what we just had as a relatively brief presentation. I just want to thank everybody on behalf of the residents of New York State. I mean, we're very clear about the objectives. Hopefully, when the next report on the status of health in New York State comes out those efforts will not have gone unnoticed or unmeasured. Thank you so much.

Mr. Kraut I'm going to call an audible here because we're going to have some quorum issues. What I'm going to ask is we have two other committees that we do have to do some votes on. I'm going to ask Mr. Holt to present the committee with the agreement of Dr. Rugge, who will delay his report to the end. I'm going to ask Mr. Holt to present on public the Codes Committee, followed by Mr. Robinson on Establishment and Project Review, and then Dr. Rugge will present on the report on health---

Mr. Kraut Mr. Holt.

Mr. Holt Thank you, Mr. Kraut.

Mr. Holt Good afternoon. At the September 12th, 2024, meeting of the Committee on Codes, Regulations and Legislation Committee reviewed and voted to recommend for adoption the following three regulations to the full council for their approval. First being reproductive health standards. Dr. Kirsten Siegenthaler of the Department presented the Reproductive Health Care Standards proposed regulations to the Committee on Code for adoption. They're available to the council should there be any questions of the members. I note an abstention from Mr. La Rue. I move to accept the adoption of this regulation.

Mr. Kraut I have a motion.

Mr. Kraut I have a second, Dr. Berliner.

Mr. Kraut I'd also like to point out to the abstention from Mr. La Rue. Dr. Eisenstein is not in the room and will not be voting either on this resolution.

Mr. Kraut Any discussion?

Mr. Kraut All those in favor?

All Aye.

Mr. Kraut Opposed?

Mr. Kraut Abstentions noted for Mr. La Rue and Dr. Eisenstein is not voting.

Mr. Kraut The motion carries.

Mr. Holt Thank you.

Mr. Holt The second was disease outbreak investigation and response clarifications. Dr. Emily Lutterloh of the department presented the disease outbreak investigation and response clarification proposed regulation to the Committee on Codes for Adoption and she's available to the council should there be any additional questions. I move the acceptance of this regulation for adoption.

Mr. Kraut I have a motion.

Mr. Kraut I have a second.

Mr. Kraut Are there any questions?

Mr. Kraut Hearing none, I'll call for a vote.

Mr. Kraut All those in favor?

All Aye.

Mr. Kraut Opposed?

Mr. Kraut Abstentions?

Mr. Kraut The motion carries.

Mr. Holt Finally, the third, the hospital cybersecurity requirements. Mr. Drew Hanson of the department presented the hospital cybersecurity requirements, proposed regulation to the Committee on Codes for adoption. He's available to the council should there be any additional questions at this time. I move the acceptance of this regulation for adoption.

Mr. Kraut I have a motion.

Mr. Kraut I have a second.

Mr. Kraut Any questions about the motion?

Mr. Kraut All those in favor?

All Aye.

Mr. Kraut Opposed?

Mr. Kraut Motion carries.

Mr. Holt That concludes my report.

Mr. Kraut Thank you very much, Mr. Holt, and thank members of the committee and the department staff who came here today to help us pass those regulations.

Mr. Kraut I'll now turn it over to Mr. Robinson to give a report of the Establishment and Project Review Committee.

Mr. Robinson Thank you, Mr. Kraut.

Mr. Robinson As you know, we batch applications at full council. Any of you that do have a particular application that you would like to have us handle separately, please indicate. Otherwise, we'll just proceed as we've got the agenda structured. This first batch mainly applications for construction Application 241134C, New York Presbyterian Westchester Behavioral Health Center in Westchester County certify two psychiatric beds and perform renovations to create a ten-bed pediatric inpatient psychiatric unit. Application. 241220C, Columbia Memorial Hospital in Greene County to convert the Greene Medical Arts Extension Clinic to a multi-specialty ambulatory surgery center in the Southwest 3 Unit. That is the first batch. Both the department and the committee recommend approval with conditions and contingencies. I move that batch.

Mr. Kraut I have a motion.

Mr. Kraut May I have a second?

Mr. Kraut Mr. La Rue.

Mr. Kraut Are there any questions on these applications?

Mr. Kraut All those in favor?

All Aye.

Mr. Kraut Opposed?

Mr. Kraut The motion carries.

Mr. Robinson Thank you.

Mr. Robinson This next application separately because of Ms. Mazzacco with conflict and recusal. She's just left the room. This is Application 241214C, Home Health Aide Service of Eastern New York doing business as Eddy Visiting Nurse and Rehab Association in Rensselaer County. This calls to acquire Fort Hudson Certified Home Health Agency Inc and add Warren and Washington counties to Eddy Visiting Nurse and Rehab Association service area. The department and the committee recommend approval with a condition and a contingency. I so move.

Mr. Kraut Thank you.

Mr. Kraut I have a motion.

Mr. Kraut I have a second.

Mr. Kraut Any comments on this application?

Mr. Kraut All those in favor?

All Aye.

Mr. Kraut Opposed?

Mr. Kraut The motion carries.

Mr. Robinson Thank you.

Mr. Robinson Please have Mrs. Mazzacco.

Mr. Robinson Could you please pronounce your name, so I get it right next time.

Mrs. Mazzacco Mazzacco.

Mr. Robinson Mazzacco.

Mr. Robinson Thank you.

Mr. Robinson The following is the next batch beginning with Application 232010B, Bridge Street ASC in Kings County to establish and construct a multi-specialty ambulatory surgery center at 79 Bridge Street in Brooklyn. The department and the committee recommend approval with conditions and contingencies. This is an exploration of the operating certificate five years from the date of issuance. Application 241060E, West ASC LLC doing business as Camillus Surgery Center. This is to transfer 70% ownership interest from six withdrawing members and the remaining member to one new member LLC. Here, the department recommends approval with a condition and contingency, as did the committee. The expiration of the operating certificate will be three years from the date of issuance was the recommendation. Application 222153B, Careful. M.D. Beacon Inc in Dutchess County. This is to establish and construct a new diagnostic and treatment center located at 252 Main Street in Beacon. Approval recommended by the Department and the Committee with conditions and contingencies Application 241178B, Harmony FH LLC in Queens County. Establish and construct a new diagnostic and treatment center at 64 35 108th Street in Forest Hills. Department and committee recommend approval with conditions and contingencies. Application 241202B, New York Metabolic and Wellness Center in Kings County establishing construct a new diagnostic treatment center at 2776 Ocean Avenue in Brooklyn. Department and committee recommend approval with conditions and contingencies. Application 241211E, Interborough Developmental and Consultation Center Inc doing business as IDCC Health Services in Kings County. Establishes Interborough Developmental Consultation Center Inc as the new operator of IDCC Health Services, a diagnostic and treatment center and its extension clinics currently operated by SLA Associates LLC at 201 Kings Highway in Brooklyn. Department and committee recommend approval with conditions and contingencies continuing on with changes of ownership. Application 231059E, Caring Enterprises Inc doing business as Health Force. A whole list of geographic service areas applies. Transferring 100% ownership interest to a new member LLC. Both the department and the committee recommend approval with a condition and contingencies. Application 231088E Allegiant Homecare LLC. Again, a variety of long list of geographic service areas. This is to transfer a 100% membership interest to a new member LLC. The department recommends approval with a condition and a contingency. I move that batch.

Mr. Kraut I have a motion.

Mr. Kraut I have a second by Dr. Berliner.

Mr. Kraut Are there any questions on any of those motion or any of those applicants?

Mr. Kraut All those in favor?

All Aye.

Mr. Kraut Opposed?

Mr. Kraut The motion carries.

Mr. Robinson These are certificates. A certificate of dissolution for the Blocker Home Inc. Department and Committee recommend approval. Flushing Manor Care Center Inc FMCC department and committee recommend approval. FMNH LLC department and Committee recommend approval. Hudson Headwaters Health Foundation Inc noting an interest by Dr. Rugge. Department and committee recommend approval. Moses Ludington Hospital department and committee recommend approval. A certificate of amendment of the Certificate of Incorporation for the Rochester Community Individual Practice Association. Department recommends approval, as does the committee. I move that batch.

Mr. Kraut I have a motion.

Mr. Kraut I have a second, Dr. Berliner.

Mr. Kraut All those in favor?

All Aye.

Mr. Kraut Opposed?

Mr. Kraut The motion carries.

Mr. Robinson Thank you.

Mr. Robinson Dr. Kalkut has a conflict for the next application and is leaving the room. He's recusing himself.

Mr. Robinson Application 241192E, NYU Langone Hospital doing business as Long Island Community Hospital in Suffolk County. This is to merge Long Island Community Hospital and NYU Langone into NYU Langone hospitals and establish NYU Langone Hospitals as the new operator of the hospital and hospice operated by Long Island Community Hospital at NYU Langone Hospital. I hope everybody understood all of that. The department is recommending approval with a condition, as did the committee. I so move.

Mr. Kraut I have a motion.

Mr. Kraut I have a second, Dr. Berliner.

Mr. Kraut Any comments on this application hearing?

Mr. Kraut All those in favor?

Mr. Kraut Opposed?

Mr. Kraut The motion carries.

Mr. Robinson This next application, noting a conflict and recusal by Mr. Kraut is leaving the room and Dr. Friedrich, who is not here.

Mr. Robinson Thank you.

Mr. Robinson Just since it wasn't clear conflict and recusal by Mr. Kraut and also by Dr. Friedrich, who's not here but nonetheless has recused himself. The application is 241249E, Vassar Brothers Medical Center and Dutchess County establish Northwell HS Inc as the sole member and active parent of Nuvance Health the active grandparent and cooperator of the Article 28 and Article 36 licensed entities co-opted by Health Quest Systems Inc. I will note here that the department has since the committee meeting received a few letters in response. We've also gotten a response from the applicant on this application and believe that that response satisfies the questions raised by those by those letters. With that, the department and the committee recommend approval of the condition and contingencies. I so move.

Dr. Boufford Second by Dr. Berliner.

Dr. Boufford Open for questions from the council members.

Dr. Soffel I'm just sort of curious. I read all of the letters that came in and I would love, since I was not able to attend the committee meeting, to sort of get a summary of what was sort of the controversy around this particular application, because clearly it generated controversy.

Mr. Robinson I'm sorry that I didn't quite hear your question.

Dr. Soffel I'm sorry. Sorry that I missed the committee meeting. In light of the letters that we have received, which I've read, can you sort of describe what was the discussion at the committee meeting about the... Apparently, there's some controversy about this application and it would be helpful to understand a little bit more.

Mr. Robinson I mean, I think that the major discussion was around the issue of the insurers being concerned that this application and consolidation would result in higher premiums because of the fact that they would be able to force higher rates. I think that issue was really reviewed by the state AG's Office, and I believe that the committee at least was satisfied that that concern was not warranted. That was the that was the essence. There was certainly a broader discussion, but I think that was the key issue.

Dr. Boufford Dr. Berliner.

Dr. Berliner Since the since the committee meeting. I've been thinking about this application a lot and also about what our responsibility is as the Public Health and Health Planning Council about acquisitions of hospital systems by other hospital systems. We've recently had an experience in New York City where a large voluntary hospital system purchased/acquired another hospital system and then quite quickly moved to close down two of the facilities, one of which one closing just approved by the Department of Health. What I would like to suggest is that in the same way that we put a limited life on ambulatory surgery centers and on other kinds of applications that we add a condition to this application. Net me just state this is not about Northwell. This is not about Nuvance. I

mean, this is just in general. I think it's something we should do going forward. I think we should put in a condition that in this case Northwell cannot sell or materially downsize any of those hospitals for five years. It can sell them. It can rearrange within its system. I think we have an obligation to the public to say if we're going to allow this transaction to go through, we want it to at least have some staying power.

Mr. Robinson Well, I would say just in response to that, that the fact is that the difference between the issue that you understandably raised around what happened in Lower Manhattan, where there was, I think, significant community concern and opposition being raised to that proposal that in this case, the community support seems to be very different. The dynamic of this transaction. In other words, I think it's not good for us to sort of generalize to that to that application what we're seeing here.

Dr. Berliner I don't disagree that this is one that has community support, whereas the other didn't. I don't disagree that this is one where the acquiring institution has gone out of its way to meet with all the stakeholders and things like that. What I'm suggesting is that when a hospital system acquires another hospital system, that the public have some guarantee that this is not going to be... You know, we're going to do this. Let me just say, I mean, I don't have any reason to believe that Northwell has any interested in selling any of these facilities or closing. If that's the case, then there is no downside to them.

Mr. Robinson I understand that. I do also would say that the... I don't know what to call it. Is it a consent decree.

Ms. Ngwashi My name is Marthe Ngwashi. I'm an attorney at the Department of Health. I think that as it relates to an application that you would like to add a condition on that has not previously been discussed by the council in a manner in which that is the specific topic area. It would not be appropriate to do that under this circumstance. It also relates to the Northwell Nuvance application or Vassar Brothers application with the best assurances agreement that was entered into by Northwell and Nuvance, both of the Attorney General's Offices from Connecticut and also from New York have put in some protections to ensure that some of the things that you are concerned about what happened. Again, as it relates to the project application, I just don't think it's appropriate for us to do a condition like that without having a more fulsome conversation about it.

Dr. Berliner I think that makes perfect sense. I've thought about that. I think in this case, if we postpone this to the next cycle to have the committee, the council or the committee or both go at it again. That would be fine. I think it's something that we should put in on a general basis. Maybe we ignore this one, but going forward any system acquiring another system for five years they can't close any of the facilities down.

Ms. Ngwashi Dr. Berliner, as a regulated entity by the Department of Health, they have to come to the department for closures anyway. We don't want to now infringe upon that process already. I do understand what you're saying, but I have to tell you that it would be a lot better to have a conversation in an appropriate forum, which would be a Health Planning Committee meeting. I can't tell you that that's something that we would be able to do in one cycle, right? That's the reality of it. I don't want that to be something that we hold an application for. I also don't know that you would get the votes for that, but that you would hold an application in this instance to be able to talk about something that's an important subject matter.

Dr. Boufford Could I just say also, I think you're raising it sounds a little bit like changing the rules after the process has been played out. You know, tying it to this particular application versus dealing with it. I was interested in the fact that there may be other tools as well. I mean, the health equity index to me was interesting. It was cited, I think, in the Northwell letter that it's not required unless there is a downsizing and as Marthe says, or a closure as Marthe says that would have to come back to us anyway. I think the dealing with it as a policy issue is important. Tying it to this particular application seems to me also problematic.

Dr. Berliner Except that... You know, I think many of us were blindsided by what happened with Mount Sinai and New York Pioneer and Beth Israel. I don't think health equity quite gets at it. What I'm talking about specifically is a hospital system acquiring another hospital system. All I'm asking is that they commit to not closing any part of that new system for a five-year period. They can sell it. They can alter things within the system. That's completely up to them. I think just as a principle going forward, whether it applies to this application or not, I think is just something that we should require of acquiring.

Dr. Boufford I've got some folks that want to comment on this. First of all, Ms. Soto, then Dr. Rugge, then Mr. Thomas.

Ms. Soto Nilda Soto, council member. Mine is more of a question or clarification along these lines. Is there anywhere in the CON process where a hospital's the best solution, the closing that they would come before on one of the CON categories? That's my question.

Dr. Boufford I think Marthe mentioned that any significant closure has to come back to the council. I don't know if it's through the CON process.

Ms. Soto Closures are handled by the department. I'm not exactly sure I'm understanding what your question is.

Dr. Boufford Is there a CON process where this this issue might be so added, I guess.

Ms. Ngwashi Again, when the applications are presented to the council at the Establishment and Project Review Committee meeting, that is a time to have some of these discussions, particularly when you have the applicant there and they have been given an opportunity to address some of these concerns. In so doing, I think that why Mr. Robinson mentioned that there was some additional feedback that had come up is just for the ability to continue to maintain transparency about the project application, but to let you know that some of those things had already been addressed. All I'm talking about is if you want to add a condition such that Dr. Berliner is mentioning, or if you're talking about doing some other things that are outside of the realm of what have already been discussed also at the EPRC meeting, that's something that would have to be done at a later time. It cannot be done on the back of an application that's before us that has already been discussed in the mechanism and which, if presented to the council.

Dr. Boufford Dr. Rugge.

Dr. Rugge I certainly understand the stress going on in Lower Manhattan, but many times mergers happen among hospital systems because of severe financial distress and also care distress. What comes to mind is an application we just approved and that is for the dissolution of Moses Ludington Hospital. This was a hospital who struggled for many years, chose with other hospitals in New York to join the University of Vermont Health

Network and over initially was alarm in the community about losing their hospital. Over time, the university was able to bring all kinds of specialty services to the community and then submit to the proposal to close Moses Ludington. It was met with overwhelming approval because the care had been so much better. I think having one generalized stipulation for a five-year delay would be unfortunate in some cases.

Dr. Boufford Mr. Thomas and Mr. La Rue, then Ms. Monroe.

Mr. Thomas Hugh Thomas, a member of the council. Just a response to you, Dr. Berliner. There's a process, a very specific process for closures of hospitals in the state of New York. Whether we like it or not, it exists. The Department of Health does that in administrative level. It strikes me to try to place a blanket or a general five-year duration post-closing on these kinds of transactions would tie people's hands too much. I think that the department really is in the best position to evaluate whether to close, whether the facility is no longer viable, sustainable, the impact on the community from an equity's perspective. I would be really reluctant to put that kind of a standard clause or condition on a CON of that nature.

Dr. Boufford Mr. La Rue, then Ms. Monroe.

Mr. La Rue Good afternoon. Scott La Rue, member of the council. I can concur with Mr. Thomas's comments because, this is a larger conversation that I think should be had at another time, not based on this particular application. My concern with a five-year limit is circumstances change. Would we have anticipated that the state legislature was going to pass a staffing mandate that costs over \$180 million to nursing homes and then fund it? Circumstances change. How do you put a five-year requirement on an application when you can't anticipate what's going to happen in five years? I think it's a bigger conversation that has to be had at a later date, not tied to this application.

Dr. Boufford Ms. Monroe.

Ms. Monroe I appreciate Dr. Berliner's concern about what happened with about Mount Sinai. I think we were all a little blindsided by that, but to then take the next application and change it in response to what happened earlier to me it's a knee jerk reaction that's not appropriate. It does need to be discussed. Perhaps, the council could take this on in health planning or wherever to really have a good discussion about what our expectations when a system buys another. I would not support adding a condition to this application at this time. I just also was surprised that the two letters we received didn't come to the committee when they would have had a chance to speak about it and we would have had a chance to talk to them. I have a hard time putting a lot of weight on these letters since they really did not participate at a time that was appropriate to the process.

Dr. Boufford Dr. Kalkut.

Dr. Kalkut I concur with you, Ann, in two ways. One is it ties hands in a way that I think is too broad based and will dissuade investment, perhaps all of that. The bigger thing, I think is a precedent setting item that if we do that here now, how do we then make policy on a single issue CON the implications for that I think are too big for other things down the line. I just wouldn't do it, as Ann just said.

Dr. Boufford Dr. Rugge, Mr. Laurence, and then Dr. Berliner.

Dr. Rugge Is that better?

Dr. Rugge Just a specific question about this application. Did the committee have the opportunity to address each of the concerns raised by the letters of opposition that we have received?

Mr. Robinson I mean, I thought we had a pretty thorough conversation on the application. It was pretty open ended. I do think that we touched on the issues that came before us at the time. As I said, I do believe that during the committee meeting the concerns raised by the insurance industry were really the ones that dominated the conversation, but we did touch on other issues as well.

Dr. Boufford Mr. Lawrence.

Mr. Lawrence Harvey Lawrence, a member of the council. I remember the conversation that we had; I think it was around Mount Sinai. At the time, I think the applicant had made some commitments about closures. At some point, I believe the council decided that through its vote that it was not... Didn't believe the applicant. We voted that application down if I understood what happened. That meant that it went to the Commissioner to make a decision about it. My memory may be failing me here. I think this is an issue that we do need to address, but maybe not on this particular circumstances. It's an issue in terms of the acquisitions that are happening and the consolidation. What are the implications for the health delivery system? I understand that there are circumstances that lead to. If there are additional costs, additional burdens those are realistic concerns. There are also concerns in neighborhoods that are dependent on these institutions that we need to address. This is not the time. We should have a broader conversation about those underlying issues and come up with a policy on the front end and also consequences on the back end that would address these issues.

Dr. Boufford Dr. Berliner.

Dr. Berliner If I'm recalling correctly, there are three main comments about this. First is the five years, actually my wife suggested I should go for ten years and then we compromise to five. It's not the five years. It's just trying to make institutions understand that if they're going to make this kind of an acquisition they have a responsibility to continue it. Second thing was about was this discussed at the committee meeting. The answer is no, because it was never raised in the letter that HPA wrote. They were looking at other things. The third thing is that unlike New York City, where there are other hospitals, lots of other hospitals, although I would argue that closing Beth Israel is a horrible mistake because there really is nothing below 34th Street in one of the largest transient populations in the world. A lot of these hospitals are solo hospitals in their region. There aren't other hospitals there. If a decision was made to close one, it would have a profound impact on that facility. The other thing is, is the question about things change. Who would expect the legislature not to fund a major change in health policy? I think the answer to that is in part, you know, the acquiring institution isn't going into this blind. It's not as if they can come out in a year and say, we didn't expect this change. You know, who knows? Maybe Medicare goes away. Maybe Medicaid goes away. Who knows what's going to happen in health policy going forward independent of what happens in New York State. I just don't think that I... Yes, of course that's a consideration, but I think if that were the case then something like this can be considered. We or the Department of Health could say, things have changed. You're not bound by that condition anymore.

Mr. Robinson I think that the other thing that may be a little bit missing here is the fact that... It's my understanding that Northwell entered into an agreement with the AG. I think the AGs of both states, but we're only concerned about New York. Those kinds of issues were part of what the agreement was with the AG. They're already legally bound by that agreement. I don't think that it's necessary for us to double dip on that. Secondly, as I said, I think that the communities themselves want this because of the fact that those institutions are struggling fiscally right now and they're having difficulty coming out the other end. Third, I would say that Northwell has a track record of, in fact, working with hospitals that are in this kind of state and turning things around. With all of that there and the agreements between the AG, I think we should be satisfied that we've got a good recommendation here and that I think this is a good plan going forward for Vassar Brothers and the other institutions that were affected by this transaction.

Dr. Boufford Let everyone have their airtime, and then I'm going to really pull this to a close. I think we're beginning to go in circles a little bit now.

Mrs. Mazzacco Michelle Mazzacco, council member. I would reiterate what many have shared about their concerns that this is not the right time or forum. I would also share grave concerns that we could be creating a situation where organizations in need of saving would not be saved by potential organizations because of the fear that this requirement would be imposed on them, and it would be a requirement they couldn't sustain. I think we have to be careful of unintended consequences.

Dr. Boufford Thank you.

Dr. Boufford I think we would call the proposal from the committee was approval, which was seconded. I think Dr. Berliner has raised an important issue. There seems to be a consensus that this needs to be not lost to this question of health systems buying other health systems, the issues of loss of capacity. The Planning Committee was suggested that we put that in as part of the minutes of this meeting so it's reflected, and we can come back and see that something happens in regard to this.

Dr. Boufford Let me call for a vote.

Dr. Boufford All in favor of this resolution?

All Aye.

Dr. Boufford Any opposed?

Dr. Boufford It's unanimous.

Mr. Robinson Got to pull my glasses out again.

Mr. Robinson Have Mr. Kraut remain out of the room.

Mr. Robinson Application 2441251E, Health Quest, Home Care Inc, which is a licensed entity with a range of geographic areas. This is to transfer 100% ownership interest to a new member LLC. As I note, a conflict and recusal by Mr. Kraut. Department and committee recommend approval with a condition. I so move.

Dr. Boufford Do we still have a quorum? I saw a major flow out the door.

Dr. Boufford Open for any questions or concerns from the members of the council.

Dr. Boufford All in favor?

Dr. Boufford Aye.

Dr. Boufford Any opposed?

Dr. Boufford Any abstained?

Dr. Boufford Motion is passed.

Dr. Boufford We have our certificates. We have two other actions. Lakeside Memorial Hospital approval was recommended, and Lakeside Beikirch Care Center approval is recommended. Mr. Robinson is having left the room. He recused himself. I'll move approval.

Dr. Boufford Second, Dr. Berliner.

Mr. Kraut All those in favor?

All Aye.

Mr. Kraut Motion carries.

Mr. Kraut We can ask Mr. Robinson to return.

Mr. Kraut I believe that is the end of the report of the Establishment and Project Review Committee.

Mr. Kraut I'll now turn it over to Dr. Rugge to provide an update on the activities of the Committee on Planning.

Dr. Rugge Thank you, Jeff.

Dr. Rugge SEMSCO, The State Emergency Services Council in late 2022 came to the Health Department with concerns about long waits in the in the ambulance to get to the Emergency Room. In turn, the Department of Health referred this in January of last year to the Planning Committee for consideration. We would just turn to do a larger discussion about E.R. overload. We chose two conditions for deep consideration because they seem not to be the most appropriate setting for the care. One was mental health; the other is dental care. With regard to mental health, we were very impressed by Commissioner Sullivan from the Office of Mental Health regarding a diversion process through 988 and also a whole continuum of dedicated expert mental health services apart from the Emergency Room setting where that kind of expertise could not be assured. Therefore, our concentration has been on dental and looking at again models elsewhere of how to divert calls. 911 calls automatically be E.R. to a more appropriate referral or setting. We had two models to draw upon. One was from California; the other is in Rochester and then elaborated on how to proceed with those concerns. I would like to think that the deliberations we were undertaken helped to make the Governor aware and sensitive to some of these issues, both by giving lots of attention in the State of the State message to

restructuring the EMS system and now with improved legislation for some \$650 million over three years to address dental concerns. Along the way, a draft report was composed and distributed to the members of the Planning Committee and also to PHHPC for further consideration with the stipulation that these recommendations or this draft should be considered confidential and with the replies only going to two network staff. As it turned out, the committee members had lots of considerations to consider, lots of analysis undertaken. In the meantime, I'm told and expert authority that the next step will be for Planning Committee meeting to rework or revise or edit the draft report for submission, then to the executive chamber for advice and consideration and hopefully for adoption. It was certainly come back to the council too, at the right time for further consideration and approval. In twelve days, there will be a meeting of Ann Monroe and myself with Dr. Heslin, Jackie Sheltry and others to develop an agenda and set a time for that committee meeting. More to follow. Thank you.

Mr. Kraut Thanks so much.

Mr. Kraut Is there any comments or questions?

Mr. Kraut Dr. Boufford.

Dr. Boufford I just have one other point before you close the meeting. It was mentioned in passing in the conversation on the prevention agenda that because of the shift in the prevention agenda, the CPN language tying CON. We've talked about this for a year or so, the language tying CON applications for acute care facilities would need to be modified. That also falls, I think, in the Planning Committee work and Dr. Fisher's office.

Mr. Kraut I think there's just a number of topics that we're going to have to get the committee chairs together to reset the agenda for the council over the next year or so. I think that's it for the day. I want to thank everybody for coming and attending. I just want to remind the next meeting of the Committee Day for the Public Health and Health Planning Council will be held on November 14th in New York City. The full council will then assemble again in New York City on December 5th, 2024.

Mr. Kraut May I have a motion to adjourn?

Mr. Kraut I have a motion, Dr. Berliner.

Mr. Kraut I have a second, Dr. Watkins.

Mr. Kraut We are adjourned.

Mr. Kraut Thank you very much for attending today.