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TRANSCRIPT

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Mr. Kraut I'm now going to call to order the Public Health and Health Planning Council of October 6th, 2022. As a reminder, I just want to repeat the requirements that we have for our open meetings. It's a public meeting via the webcast. There's a forum that needs to be filled out, which records your attendance at this meeting required by the Commission on Ethics and Lobbying in accordance with Executive Law 166. The form is also posted on the Department of Health's website under www.NYHealth.Gov under Certificate of Need. We ask you to email the completed forms to Colleen.Leonard@Health.NY.Gov before the meeting. Thank you for your cooperation in us complying with this law. We're subject to the Open Meeting Law. Therefore, we're broadcasting over the internet. Keep yourselves on mute when not speaking. Avoid the rustling of papers and stuff. It will pick up personal conversations and chatter we'd like to keep to a minimum. We're doing synchronize captioning as well, and we need to make sure that no one is speaking over each other. It's really hard to do the captioning of two people speaking at the same time. The first time you speak, we'd ask that you identify yourself as a council member or a member of DOH staff. This will be helpful to us. I want to encourage everybody to sign up on the Department of Health Certificate of Need Listserv. We regularly send out important council information and notices as soon as it's available, such as the agenda, the content for the agenda, the meeting dates and policy matters. All the material presented before the council is available online for those to review prior to the meeting. There are also printed instructions on the reference table outside of the meeting rooms on how to join the listserv or just contact Colleen Leonard at the email I had previously done. Today, we're going to hear from Dr. Bassett about the Department of Health activities, followed by Dr. Bauer about the Office of Public Health, followed by Ms. Morne, who's going to give us some insight into her new appointment as Head of the Office of Health Equity and Human Rights, followed by Dr. Morley with the Office of Primary Care and Health Systems Management. Mr. Herbst will be filing a report on the Office of Aging and Long Term Care.

Mr. Kraut I'll ask Mr. Holt to present the regulations for emergency adoption of the Codes Committee.

Mr. Kraut Wait a minute. I think I screwed that up, right?

Mr. Kraut And then what we're going to do after that is we're going to do... Mr. Holt will do Codes Committee, Mr. Robinson will do Establishment Review. We'll hear from Ms. Royal from the Office of Aging, who will present the long term care abandonment project. Finally, Mr. Hennessey and Ms. Shulman will talk about the clinical staff overview.

Mr. Kraut Just before we get to the Establishment Review Committee report, we've batched the applications, so we would ask everybody to take a look at them, make sure there's no issue you have on how we batched them. If there is, please make us aware of it and we'll remove any batched applications.

Mr. Kraut I'd like this time to congratulate Ms. Soto, who's recently retired from her position at the Albert Einstein College of Medicine. She has been a dedicated employee for the past thirty-two years. You've served as the Assistant Dean to the Office of Diversity Enhancement and Director of the Einstein Enrichment Program. We are very thankful that Ms.. Soto has agreed to continue to serve out her term on the council. We appreciate it. We wish you well on the next leg of your professional journey, but we're really pleased it's including a stop and stay here. Thank you very much, Ms. Soto.

Mr. Kraut I need a motion to adopt the June 2nd, 2022 public health meeting minutes.

Mr. Kraut May I have a motion?

Mr. Kraut Dr. Berliner.

Mr. Kraut A second by Dr. Gutierrez.

Mr. Kraut Any issues with the minutes?

Mr. Kraut All those in favor?

All Aye.

Mr. Kraut Opposed?

Mr. Kraut The motion carries.

Mr. Kraut Now, I needed a motion to adopt the July 28th 2022 meeting minutes.

Mr. Kraut Dr. Berliner.

Mr. Kraut A second by Dr. Gutierrez.

Mr. Kraut Any issues or corrections?

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

Mr. Kraut All those in favor?

All Aye.

Mr. Kraut Opposed?

Mr. Kraut The motion carries.

Mr. Kraut I need a motion to adopt the September 15th, 2022 special meeting minutes.

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

Mr. Kraut A second by Dr. Gutierrez.

Mr. Kraut Any issues with those minutes that were provided to you?

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

Mr. Kraut All those in favor?

All Aye.

Mr. Kraut Opposed?

Mr. Kraut Motion carries.

Mr. Kraut I'll now turn it over to Albany.

Mr. Kraut Dr. Bassett has joined us.

Mr. Kraut Dr. Bassett, welcome.

Mr. Kraut The microphone is yours.

Dr. Bassett Thank you, Mr. Kraut.

Dr. Bassett Good morning, everyone. It's a real pleasure to be back with you today. I'm going to give some quick updates first about what we have called the big three here at the Health Department; that's COVID, polio and monkeypox and then I'll move on to talk about the prevention agenda, which continues to address the leading causes of death in our state. As we settle into the Fall and we all are enjoying the beautiful weather with the morning chill, we want everyone to remember, as Dr. Bauer has reminded us on previous occasions, that COVID is still very much with us. As of yesterday, we were running close to 21 cases per 100,000, and we had 2,425 patients hospitalized with COVID yesterday. We are still losing people to COVID. We had 19 new deaths reported through our surveillance system yesterday. As you all are aware, we have reduced the restrictions that we had related to public health measures of masking and distancing. We are relying increasingly on the protection that vaccines provide. Vaccination is what has changed the face of COVID and reduced its impact in terms of severity and death. The new Bivalent booster is here. The shots are available. They will greatly improve our ability to protect New Yorkers from the rising rates of transmission that we expect to see in Winter months. We're also expecting to see Pfizer and Moderna approve this new Bivalent vaccine for emergency use in children, children five and older for the Pfizer vaccine, which has been really the mainstay of MRNA vaccines or vaccines in general in our state and for children six and over for Moderna. This is a plea I make every time I have a microphone. I want everyone who is eligible to get their booster to go out and get their booster and remind you also that this is flu season upon us. We would like you to get your flu shot as flu cases are on the rise in the state and at this time, flu transmission in the state is considered widespread. To get this point across, we're going to be launching a flu COVID vaccine campaign. We are going to be promoting the Bivalent vaccine through paid medium. That will include targeted digital advertising, social media and other means. So, that's the news on COVID. We have a booster that addresses for the first time our leading circulating variant. That's the BA45 variant. We want everyone who's eligible. That means if you haven't been vaccinated and haven't had COVID in the last two months, you're eligible for the Bivalent booster if you're over 12.

Dr. Bassett Let me turn now to polio. On July 21st, we announced that a young person was diagnosed with paralytic polio who was resident in Rockland County. The department began looking at wastewater, which is a polite word for sewage, because people polio virus in their guts. We began looking at it in Rockland and other counties to see if we could detect polio virus in wastewater in these communities. We found evidence of polio virus in Orange County, Sullivan County, in New York City and Nassau County. This virus has been sequenced and linked genetically to the person who developed clinical paralytic polio. This is the evidence that we have for the ongoing circulation. We've continued to detect virus in wastewater, and we are working hard to address this. The answer is simple to proclaim, but challenging to execute, and that is vaccination. We're providing operational and outreach and communications support to these counties, working collaboratively with their health departments and with other community partners to share the facts, increase awareness and encourage people to be vaccinated. As you know, the declaration of an emergency enabled us to expand our pool of vaccinators for polio, an important part of our response.

Dr. Bassett Let me move on to monkeypox. This was something that was really just an artifact of medical textbooks. Until mid-May of this year, when we began the current outbreak of monkeypox, which has spread to involve more than 90 countries and has involved, I think, where there may be one state that has not had a case diagnosed, but virtually every state in the United States has diagnosed a person with monkeypox since mid-May. We have at this time 3,889 cases. That's the latest data as of Tuesday this week. Almost all of these cases are in New York City and in the Downstate area, meaning two thirds of the 334 cases diagnosed outside of New York City have been in Long Island and Westchester. On July 28th, I declared monkeypox an imminent threat to public health, and that was followed by the Governor's declaration, and it was subsequently followed by a national act. We have provided clinical guidance for the testing of monkeypox through initially all public health labs, but now increasingly also private labs. I think about a quarter of current testing is done by our Wadsworth Lab and the rest is now done by private labs. And we, of course, are working hard to distribute the vaccine through both federal and local partners, which you've heard a bit about already. We are encouraged that the rate of increase of monkeypox cases has really slowed. It appears that we have, you know, sort of reached a point where certainly the outbreak is no longer growing. This is true in New York City as well as in the rest of the state. This is the joint action of the affected community as well as the availability of vaccine. We are continuing to engage communities and provide information and work with advocates and activists and the LGBTQ community. We have longstanding relationships with these, principally through our AIDS Institute, but also through other parts of the department. You will hear more from our Deputy Commissioner for Health Equity and Human Rights, Joanne Morne, who you may have already known as the Director of the AIDS Institute. She has already talked with you about the importance of the act that the council is just taking and designating monkeypox as a sexually transmitted infection. Just to reiterate, we don't want a sexually active minor. Regardless of whether parents want their children to be sexually active or whether any adult wants them to. We know that children report that by the time they finished high school, half have engaged in sexual activity. If you are a young boy engaging in sex with men or boys, we want you to have the right to protect yourself. You have just enabled that. This is simply about access and the protection of our youth.

Dr. Bassett With those words, I'll go on to say a bit about the Prevention Agenda. We are on a five year, I think it's five years anyway. It's 2019 to 2024. A plan of the Prevention Agenda, which calls on cross-sector partnerships to address the facts of everyday life that we refer to as social determinants of health that enhance the burden of disease. There are

five priority areas for specific action. Most of this work is overseen by our Office of Public Health. I'll ask Dr. Bauer to also join me in answering questions about it, if there are some. Let me just go over for you the priority areas. They include the prevention of chronic disease, the promotion of a healthy and safe environment, the promotion of health for women, infants and children, the promotion of well-being and the prevention of mental health and substance use disorders. And, of course, the prevention of communicable diseases, a task that has occupied most of my tenure. The prevention agenda provides communities with recommended evidence based interventions and information on promising practices and guidance, and that emphasizes interventions that don't place blame on individuals for unhealthy patterns, but addresses the need for healthy environments that promote healthy choices and the need for equity across communities. There are action plans around all of these priority areas that are broken down into focus areas, goals and objectives. We're committed to tracking progress with measures that reflect the implementation and impact of evidence based interventions. These are all tracked in the prevention agendas dashboard, which can show progress or challenges. As you might imagine, the COVID pandemic posed a substantial challenge to the prevention agenda. I'm very pleased to be talking with you about it as we readdress these important causes of health. I'm going to go through each of these categories. The first one, as you'll recall, was preventing chronic disease. We have seen an improvement in the proportion of adults over 50 who've had a colorectal screen. It went from 66.3% to 91. Sorry, I misspoke. I wish it were 91, but it went from 66.3% to 71.8% in one year. There has been progress in asthma management with asthma related emergency departments in the pediatric age group, and that's people under 18. Fell from 138 in 2016 to 100 in 2019. Medicaid managed care members identified with persistent asthma and given the right medications for their asthma management. It has been rising steadily. It was just at 50% in 2014 and had risen to 60% in 2019. Obviously that's progress, but hardly perfect. We want to see that proportion continue to go up. Obesity is a stunning challenge to the health of our nation and our state. The obesity rate in children which had leveled and begun to drop until 2015 has now started to inch up again. We estimate that 13.9% of children, 2 to 4 years old who are in the WIC program are obese. Obesity begins very early. Also important is smoking cessation. We have been helping smokers to quit. With smokers enrolled in Medicaid, the proportion dropping from 24.3% to 19.9% in one year. Additionally, we track blood pressure. I mean, sorry. Blood sugar elevations as a measure of diabetes in the population. We're hopeful that we're doing better at managing people with diabetes. Blood sugar elevations have fallen between 2019 and 2020. They fell from 69.2% to 60.4%. That was quite a big drop for just one year. The next objective is to promote a healthy and safe environment. That's seen a lot of improvements across all categories. Crash related pedestrian fatalities rose however. I'm going to tell you the bad news. That's how we work in public health. We own up to our challenges. Crash related pedestrian fatalities rose from 1.3 to 1.9 per 100,000. The annual number of days that the air quality was above 100, which is unhealthy. That number of days has increased. It was 12 in 2020. It went up to 20 days in 2021. We had hoped to achieve a level of three days by 2024, but at this time our confidence in achieving that is waning. There has, as I've said, been progress. The percent of people living in a certified climate smart community has doubled from 15.1% to 31.3%. That's between 2019 and 2021. The number of homes inspected for lead and other health hazards, as well as homes tested and mitigated for radon, has significantly improved, and public water systems that were awarded infrastructure improvement assistance has doubled from 28 public water systems to 56. The third objective, promoting healthy women, infants and children. Most of our focus areas, there have been declines, not improvements. We're all very well aware of the rising tide of opioid use, including fatal overdoses and the number of newborns born with neonatal withdrawal symptoms per 1,000 live births has improved in spite of that from 9.6

to 7.9. That's between 2018 and 2019. I hope our more recent data will confirm that. Additionally, we're getting more participation in the early intervention program where we, the proportion of families who meet the state standard for impact on family scale has improved from 67% to 93.9% in 2020. That was the good news. Newborns with neonatal withdrawal and improvements in delivery of services in the early intervention program. There is less rosy news in the maternal mortality rate. That rate rose from 18.1 in 2016 to 19.3 in 2019. The disparity in Black and white maternal death rates also widened. The ratio grew from 4.68 in 2014 to 5.31 in 2019. We also saw a reversal of progress in the proportion of births that are preterm from the lowest level in 2015, which was 8.7%, which was pretty close to the prevention agenda goal of 8.3%. We have instead seen a rise from 8.7% to 9.2% in 2019. The percentage of women who talk with a healthcare provider about ways to prepare for a healthy pregnancy fell from 43% to 35%. Suicide, and this is a national observation, has been rising in youth with deaths rising from 4.6 per 100,000 to 6.2. Mental health and substance use disorders are, and many of the focus areas under this pillar showed improvement, despite the fact that we are all aware that people's mental health has truly been challenged in recent years. These data come from before COVID that the proportion of adolescents with major depressive episodes grew from 10.8% in 2018 to 12.9%. There were these improvements. Binge drinking in young adults improved. People who got at least one buprenorphine prescription for opioid use disorder improved. Emergency department visits for any opioid overdose improved slightly. Indicated reports of child abuse and new maltreatment fell. The last category is about communicable diseases, and you all know that we have been heavily focused on COVID, on polio and on monkeypox, but there are other communicable diseases which we concern ourselves with, and in this case, sexually transmitted infections, old infections of gonorrhea. I mean, these ones we've known of for many, many years. Gonorrhea, chlamydia and syphilis are going up and our immunization rate in children has declined. There has been some progress. For example, the immunization of adolescents for HPV, the principal risk factor for a number of common cancers, including among girls, cervical cancer. That proportion rose from 28 to 30, nearly 40% in 2020. The number of newly diagnosed HIV cases declined between 2010 and 2019. I spend some time on all of these issues just to remind all of us of the scope of work of the health department. We are very much committed to the whole health of the population, which extends beyond the control of microbes to include the environment, non-communicable and chronic disease. I very much look forward to our continued progress on COVID. That's why I want everyone who is eligible for a booster to get boosted, so that we can turn to these and direct department attention to these long standing challenges to the health of our population.

Dr. Bassett With that, I'd be happy to answer any questions and I'll conclude my remarks.

Mr. Kraut Thank you. Thank you very much, Commissioner, for that extensive report.

Mr. Kraut This is the Ask Commissioner part of the council meeting.

Mr. Kraut Any council members here or in Albany have any questions?

Mr. Kraut I'll turn it over to Dr. Boufford first.

Dr. Boufford Thank you very much. I want to thank you for bringing up and reminding us about the prevention agenda. I really very much value the ongoing work of the department in the face of the acute challenges that you've had. I know this council and the Public Health Committee of the Council have been quite eager to restart, if you will, our sort of ongoing conversations on the prevention agenda, as well as the issue of maternal

mortality, which had been an early concern of the council. In fact, I think as long as 4 to 5 years ago had sort of generated paper that has led to the Governor's commission and much of the other activity that's going on. I just want to thank you for raising that again. We look forward to working with you to put these other elements back on the public health agenda.

Mr. Kraut Thank you.

Mr. Kraut Any other questions?

Mr. Kraut Dr. Kalkut.

Dr. Kalkut Thanks again for the report, covering a whole spectrum of problems that we face. I had a question about COVID and the CDC mask suggestions or recommendations that were from a couple of weeks ago, which allowed facilities to in non-high transmission areas to change masking requirements right now. Dp you anticipate the state weighing in on that or commenting on that announcement from the CDC?

Dr. Bassett Yes.

Dr. Bassett Thanks.

Dr. Kalkut Is that a problem?

Dr. Bassett I think of the principal location where we have continued to require masking; our health care facilities, which include nursing homes. We have continued that as a universal requirement, not only in patient facing areas, but throughout the facility. I don't know if you've had a chance to look recently at the map on transmission. You have to look for it because if you Google, you know, COVID levels, you'll end up with a different map, which shows what the CDC now calls community levels, which measures basically hospitalizations and hospital capacity as the principal sort of determinants of what the level will be after cases past a certain point. If you look at the transmission map, the last time I looked at that, which was a couple of days ago there updated actually today. We can all look at it today. The map on transmission was still all red, meaning that we as a state continue to be in the highest level of transmission. We're going to hold on to masking in settings which has elderly people who are, of course, our most vulnerable, the people who are getting infected, getting hospitalized and dying are principally people over the age of 65 during our current period. We really want to be very careful. I hope that that answers your question. We continue to meet the CDC guidance. I don't expect that that will change or that we will drop masks in health care settings. We no longer have masks required in schools, public indoor places, transport, except for the individuals who choose to wear them. I hope that we'll all work to try and reduce the amount of stigma that is attached to mask wearing. I have had the experience personally on numbers of occasion of entering the hall where I'm the only person present who is wearing a mask. I hope that we can get to the point where, you know, where that person and in this case, that person was me, doesn't feel like we've possibly done something wrong. Everybody should take the action that they need to protect themselves. In hospital settings, we are going to continue. People don't choose to end up in the hospital. We're going to continue to maintain the protection of masks. In this case, we are fully consistent with CDC guidance.

Dr. Kalkut The map is as red as it was a few days ago for New York State. The CDC comments that three quarters of the counties in the United States are still considered high

transmission rates. It's a small part that would even consider these regs following it directly.

Dr. Kalkut Thank you.

Mr. Kraut Any other members of the council?

Mr. Kraut Anybody in Albany?

Mr. Kraut Commissioner, thank you so much for the report. We look forward to our next visit.

Mr. Kraut I want to introduce Ms. Morne, who's going to give a report on the activities of the Office of Health Equity and Human Rights.

Ms. Morne Good morning. Thank you again. As said, my name is Johanne Morne. I am the Deputy Commissioner of the newly created Office of Health Equity and Human Rights within the Department of Health. I'm proud to lead this effort as well as this team. The department's reorganization has created a step towards the department's goal of increasing diversity, equity and inclusion within our workforce as a part of the overarching mission to build a healthier, more equitable New York State. While critical milestones have been achieved by the department, we know that we must continue to prioritize our response to the persistent, glaring disparities, so gains are realized equitably by all populations. No matter what progress has been made in the department, we cannot achieve our goals to improve health outcomes if some communities remain left behind. The Office of Health Equity and Human Rights is charged with working across the department to address health disparities, as well as to reduce those disparities across racial, ethnic and socioeconomic groups while leveraging data to inform policy and improve overall health outcomes. In brief, the goal is to improve health equity, reduce health disparities, and better support marginalized and underserved communities. The office is currently made up of three established offices within the department that includes; the AIDS Institute, the Office of Minority Health and Health Disparities Prevention, as well as the Office of Gun Violence Prevention. Additionally, we are in the process of building an additional office, the Office of Diversity, Equity and Inclusion. Collectively, these offices have a broad portfolio. The AIDS Institute oversees services related to HIV, AIDS, STI's and Hepatitis C. The AIDS Institute also houses the Office of Drug User Health that works towards the health and wellness of individuals who use drugs, as well as supports the LGBTQ Health and Human Services Network. The Office of Minority Health and Health Disparities Prevention works to ensure that all New Yorkers have access to health care services and other support services with an overarching objective to ensure that marginalized communities are prioritized in the efforts that we make to achieve health for all. The Office of Gun Violence Prevention, newly established about a year and a half ago, was developed to focus on the public health impact of gun violence within a number of vulnerable communities across our state. Community engagement is the foundation of the work that we do across the department and certainly within this office through close allyship with community partners and stakeholders. It is our intention to build on the historic advancements that have been made as it relates to the work that cuts across equity, health care access, promotion of anti-stigma and certainly anti-racist structure as well as the preservation of human rights. We've set a number of ambitious goals for this office to achieve by the end of the year. I'll offer just a few examples, including the establishment of three working groups that will help to inform DOH planning, multiple state agency planning and community stakeholder priority setting. We'll be working to initiate the

development of the New York State Department of Health, Health Equity and Human Rights Blueprint in an effort to offer a universal set of goals and objectives. We will also be working to develop and facilitate Department of Health staff training related to diversity, equity and inclusion. Many of us are already at the table working to establish a department wide definition of health equity as well as health disparities. We will continue to do the work regarding data modernization. On behalf of the entire team that already has done tremendous work within this office, we look forward to our continued work ahead. We are absolutely committed to working towards the goal of achieving sustainable change, the process of making sustainable improvements that will last over time.

Ms. Morne Thank you.

Mr. Kraut Thank you very much.

Mr. Kraut Is there any comments or questions?

Mr. Kraut Dr. Boufford.

Dr. Boufford Again, just to welcome you, Commissioner Morne.

Dr. Boufford Excuse me.

Dr. Boufford To say how important it is for your arrival and consolidating the number of the areas that have been looking at the issue of vulnerable populations and diversity, equity and inclusion. This has been a a gap in the work on the prevention agenda that many of the local communities who are charged to identify two of the five goals in their action planning going forward, in addition to one area of health disparity to work on in their communities. Many of them have requested technical assistance support and other help in this area. I'll be coming to you to talk to you about that very quickly. I think it's very encouraging. We look forward to working with you on the further development of this area of the prevention agenda.

Ms. Morne Thank you very much.

Mr. Kraut I'll just put in my $0.02 since you kind of went through it. It's a passion of mine. You talked about the importance of getting data and using that data. In probably no other policy agenda will good data drive good policy. I implore you to work with your colleagues to get the most important database that we have that has not been available to providers and researchers and people that are interested in this is the all claims database. The only database the state has that we can actually visualize a journey and where people seek care and where they have problems accessing care. I would hope that your group would have some influence on getting that data into the public domain, so we could start using it for the types of objectives that you raised. I'm not asking you to respond. I'm just making another plea to another person maybe that might be able to do something about it.

Mr. Kraut Mr. Lawrence.

Mr. Lawrence Harvey Lawrence, a member of the council. Commissioner Morne, I'd like to commend you because this is a pretty ambitious agenda that you've established. Working at a community health center, we see disparities, especially related to chronic disease, many of which have existed in our neighborhoods for decades. We've had all types of approaches to address them, but none seem to really be able to get out in front

and make meaningful changes in the lives of the people that we serve. Beyond the broad policy goals and objectives, I think the real measure of success is whether we reduce obesity, we reduce hypertension, whether we reduce diabetes, rates of cancer. In Brooklyn, we have probably the highest rate of prostate cancer. That has persisted for a while. I welcome this opportunity, but I also know that at some level you got to cut through some of the policy and really look to how do you make meaningful change in the system that results in meaningful improvements in the lives of people in many of the neighborhoods that are served by community health centers around the state. I just needed to welcome you, because this is something that at the State Association of Community Health Centers we've been looking at and working about, talking about and strategizing around how do we, in fact, move the needle in a pretty dramatic way to improving outcomes?

Mr. Kraut Thank you.

Mr. Kraut I'm just going to ask if we could wait a moment. We have a technical problem which we need to resolve. I'll come back to Ms. Soto next for a question. We have a problem where we're not being visible on Zoom. The folks in this room. Is that correct?

Mr. Kraut In Albany.

Mr. Kraut They can't see us. They blacked out over here. We're permanently black. They need to reset the system. They just asked us to pause for a minute until we can do so.

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Ms. Soto I'm the past Chair for the New York State Minority Health Council. One of the things that I was listening and I honed in on that we are looking at not only diversity and inclusion, but that key equity piece, because we have, over the years New York State has worked at identifying and increasing. As you pointed out, and we continue to have marginalized communities, individuals in terms of access. I was pleased to hear that it's not only going to be diversity inclusion, but the issue of equity.

Ms. Morne Thank you.

Mr. Kraut Any other questions?

Mr. Kraut Well, we're obviously, you know, as part of the prevention agenda, as Dr. Boufford said, and the issues Ms. Soto just brought up. We're looking forward to working with you and for other times to come here and work with our committees and to advance your agenda, which is 100% aligned with what we want to do. We want to spend more time on things that have higher value for the state with respect to public health and health equity. I think you'll have a great partner in this council. We wish you well.

Ms. Morne Thank you very much.

Mr. Kraut Thank you.

Ms. Morne I look forward to our work together.

Mr. Kraut Thank you.

Mr. Kraut I'll now turn to Dr. Bauer to give her report on the activities of public health. Again, I apologize for skipping over you.

Dr. Bauer Thanks so much.

Dr. Bauer Good afternoon. Ursula Bauer, Deputy Commissioner for Public Health. Thank you for this opportunity. As Dr. Bassett noted, we've been working hard to address our multiple public health emergencies to include the on going COVID response and our continuing efforts to slow or even stop the spread of MPV, monkey pox and polio along with all of our usual responses. In addition to our unprecedented emergency responses, we're also working hard to rebuild the Department and the Office of Public Health. We need to rebuild from the disruption we experienced during COVID when greater numbers of staff retired or left the department, standard operating procedures sometimes fell by the wayside, and expectations of that 24/7 work cycle exhausted staff and reduced morale. These issues continue to affect the department and the office. We also need to rebuild from a decade of declining resources prior to the COVID-19 pandemic, beginning with that hiring freeze back in 2008 that was lifted in 2021 and regular budget cuts to the department throughout the twenty teens. These left the department in a weakened condition even before the pandemic arrived. Today, I'll focus my report on OPH's rebuilding efforts. It's through progress toward rebuilding that we improve our capacity for our emergency response and regain our ability to wholly focus on our public health priorities. As you've heard previously, the department underwent a modest restructuring back in August and adopted eight strategic priorities to guide our work over the next three years. These strategic priorities don't replace our current efforts, but rather build on them and provide a frame from which to guide our progress. Aspects of the restructuring that affect OPH our rebuild efforts in addition to the exciting new offices that have been created include the location of the regional offices within the Office of Public Health, the transition of our Office of Emergency Preparedness to the Executive Deputy Commissioner. And then, as you heard from Deputy Commissioner Morne and the transition of the AIDS Institute and Office of Gun Violence Prevention to the new Office of Health Equity and Human Rights. The strategic priorities of particular relevance to the rebuild effort are making DOH a great place to work, making DOH an impactful, collaborative and efficient organization, preparing for the next emergency and strengthening the relationship between the department and the local health departments. OPH's rebuild efforts are focused on hiring staff as a top priority, and we've onboarded hundreds of staff in the past year. The progress is slow, however, because the hiring process is slow and we're not in a great hiring environment and because many new hires come from within the ranks of the department, which is great because we're promoting people and giving people new opportunities. Of course, we're also creating another vacancy that needs to be filled. Even as we do all this hiring, more people retire or leave the department for other opportunities. Regaining our full strength will take years and this work is underway. I'm thrilled to welcome the regional offices to the Office of Public Health. The regional offices are critical to the department's ability to reach into communities, to support the local health departments, and to restore the trust that was shaken during COVID. The regional offices themselves are somewhat fragile structures, though, with no funding stream of their own and dependent on programs for their staff. Many regional office staff, like many OPH staff are grant funded, so they lack the flexibility to address core or emerging public health needs that fall outside their particular scope. We need to develop an operating model for the regional offices that ensures that basic structure to each, a basic complement of staff, and a robust ability to engage in communities and provide strategic resources to the local health departments. This work is underway. The success and impact of our public health work is dependent upon the success and impact of our local health departments, like the

Office of Public Health and the department overall, LHD's were hard hit by the COVID pandemic response. Losing staff and having difficulty hiring slowed by cumbersome bureaucratic processes. These have plagued all of us in our public health endeavors. In addition, the COVID response severely stressed the relationship between the department and the local health departments. We're working hard to rebuild and strengthen those relationships. We've partnered to re-establish biweekly leadership meetings with the steering committee and biweekly meetings with the full membership. We've also instituted a quarterly meetings with Dr. Bassett and the local health departments. I understand she's the first commissioner to hold quarterly meetings with the local health departments. In June, we completed more than twenty focus groups with local health department and DOH leaders to identify best practices from our COVID response that we can institutionalize in our partnership going forward. We're wrapping up now a set of six workshops to establish group norms and supporting behaviors to help OPH and the local health departments solve problems together. Our rebuild efforts underway also include improving our critical information technology infrastructure and data systems, finalizing plans for the new Wadsworth Center Public Health Laboratory Building and preparing scores of budget proposals to address our long standing and new needs to restore our strength and develop new capabilities and programs. Much of this rebuild effort will be aided by a new grant from the CDC that we expect to receive notice on this month called the Strengthening Public Health Workforce Foundational Capabilities and Data Systems Grant. We applied for about 135 Million over five years, with the bulk of those funds dedicated to workforce and frontloaded in year one of the grant. Funding will address longstanding and new challenges to New York's public health infrastructure. OPH proposes to make strategic investments in all three of those areas focusing on workforce with more than eighty new positions proposed. While the grant addresses overall public health capacity, CDC expects us to focus on communities that have been economically or socially marginalized, are located in rural geographic areas or are composed of people from racial or ethnic minorities, or those disproportionately affected by by COVID-19 or other public health priorities. Specifically, we will deploy these funds, these grant funds to rebuild our Office of Public Health by creating and filling new positions, by expanding environmental health, emergency preparedness and public health laboratory capacity, and by improving the availability and use of workforce wellness opportunities that was another focus of the funding opportunity. We'll strengthen the regional office infrastructure, including new staff positions to expand community engagement activities and re-establish a freestanding regional office to serve the seventeen counties in the Capital District. We'll strengthen relationships with our local health departments through direct provision of funding to local health departments to hire or retain staff or invest in other public health essentials. Collaborations with local health departments to identify and deploy solutions to public health problems. Ongoing and regular communication with our local health departments to foster that strong partnership. We'll enhance and expand public health training for local health department and OPH staff through the establishment of partnerships and training units within our office, with a focus on public health essentials, understanding and addressing root causes of health inequities and building community engagement to empower, support and transform communities. We'll establish a multidisciplinary Health, Wealth and Wellbeing Unit for the purpose of exploring health and non-health data, identifying innovative cross-sector solutions and empowering communities to address foundational causes of health inequities. Finally, we hope to have resources to advance and align with the work of our data modernization initiative that's currently underway as part of our epidemiology and laboratory capacity grant. Anticipated outcomes over the five year project period include increased hiring of diverse staff, improved organizational processes and systems and progress toward a more modern and efficient data infrastructure. These will lead in the longer term to a stronger and better equipped public

health workforce and expanded and stronger capacity to address longstanding and emerging public health challenges and increased availability and effective use of public health and other data to drive program policy and other decision making. Eventually, if sustained, this program of work will result in improved public health outcomes, including reductions in health disparities and inequities. The grant is well-timed to align with the prevention agenda cycle. As you know, the 2022-2024 Community Health Assessment and Community Health Improvement plans are due at the end of the year. Planning for the 2025 to 2030 cycle is due to get underway early next year. This will be my first engagement with the prevention agenda planning process since I joined the department about a year ago. I'm optimistic that with our progress on the rebuild efforts and a more manageable emergency response demands, we and our local health department and nonprofit hospital partners will be able to make the next six year cycle particularly effective and impactful for New York's communities.

Dr. Bauer Thank you.

Mr. Kraut What an agenda you've just laid out. We wish you well. We're here as a dependable partner. One of the things, obviously, we've all had to focus on the urgent, sometimes displacing the important and the work that we'd like to return to that's aligned and frankly, integral to some of the objectives you spoke about is the work of our public health committee and focusing on the prevention agenda along with our planning committee. What's the most critical need that we have now is to restart and align our committees agenda with that of the department and to ensure that the department provides the resources to that committee to begin its work. We're going to look forward to that. I know Dr. Boufford has plans to schedule some of those meetings, and we expect to resume the work in earnest in the weeks and months ahead. I really do thank you. I think we're just, I think, delighted with the ideas and objectives that you've laid out.

Mr. Kraut Is there any other questions?

Mr. Kraut I'll got Dr. Boufford and then Dr. Gutierrez.

Dr. Boufford Thanks, Dr. Bauer.

Dr. Boufford Obviously, you know that how encouraging it is to hear what you're saying. As Jeff said, I just to reinforce what he said. I think the other piece that's really important in the discussion you have opened is the potential links for public health prevention agenda related social determinants of health activity in relation to the new waiver. That's I guess the latest version has gone in. It is pending at this point. I think discussions, you know, with the Office of Planning, with the Medicaid office and others relative to the important potential for improving conditions in communities along with the health care agenda in the waiver is something that I hope we can also take up.

Dr. Boufford Thank you for that.

Dr. Bauer Thanks very much, Dr. Boufford.

Dr. Bauer I'll just say it's a real priority of Dr. Bassett to leverage the health care side and the public health side of the department and ensure that we're working together. We've had those discussions in her Cabinet meetings and really look forward to leveraging the resources and talent on the council to make that happen.

Dr. Bauer Thank you.

Dr. Gutierrez Thank you, Dr. Bauer.

Dr. Gutierrez I have over five decades of involvement with medicine, and I want to make a remark that Dr. Boufford has heard me made before. I find that as a community have very short memories. We don't remember. We don't realize that many of us are here today because of public health. Forgotten the advancements in longevity brought by public health. We find ourselves defending what we do when in fact, I feel that we ought to be celebrating what we have achieved at the same time that we tell people that in order to defeat a disease, we need to do certain things that cannot be avoided. As a medical student, I saw polio aplenty. I saw smallpox. I saw listeria. I saw typhoid fever. Those things were keeping infectious disease hospitals full all the time. We don't see that anymore. My children know about it because I talk to them about it. My granddaughters know nothing about this. They wonder why we have to worry about polio. They wonder why we have to worry about measles. Educating the public, I believe, ought to be a duty of the health department. I'm making this remark once again, because I would like to see some part of the health forum dedicated to education beginning at the school level.

Dr. Gutierrez Thank you.

Mr. Kraut Thank you so much.

Mr. Kraut Ms. Monroe.

Ms. Monroe Thank you, Dr. Bauer.

Ms. Monroe This was very exciting. You said you asked for 135 Million from the federal government. Did you get it all?

Mr. Kraut I think you applied.

Dr. Bauer That's what we applied for. It's over five years. We will hear this month what our funding amount is.

Ms. Monroe You don't know yet if you're getting any of it or are you...I'm just wondering where you are in the process of the things you talked about.

Dr. Bauer We submitted our application on August 15th. We are quite confident that we will receive an award. I anticipate every health department will receive an award. The question will be what the amount of that award is. CDC had a very complicated three page funding calculation. They put us through a lot of work to come up with the amount that we could apply for. I anticipate they will fund us fairly close to that amount.

Ms. Monroe I just want to be sure that some of the agenda that you laid out is achievable, even if we don't get the full amount. We'll be looking forward to hearing that from you.

Mr. Kraut We'll see where we're permitted to help. Just echoing, you know, what you're basically saying, what Dr. Bauer said, and particularly the cogent comments of Dr. Gutierrez. Next year is the 110th year of the Public Health Council in New York State. We're the steward of a mission that has gone unbroken and met tremendous challenges over the past hundred and ten years. I think it's exciting of some of the direction that Dr.

Bassett, Dr. Bauer, Ms. Morne has laid out. That's not to negate Dr. Morley and Mr. Herbst who's following them. I just thought I'd take this opportunity to say this is a good time to reset the priorities of the council and focus on what can make the maximum impact on the health of all New Yorkers.

Mr. Kraut Dr. Bauer, I thank you so much. I appreciate you. Obviously stimulated a lot of conversation.

Mr. Kraut Dr. Morley, we'd love to hear from you on the Office of Primary Care and Health Systems Management.

Dr. Morley Thank you very much, Mr. Chairman.

Dr. Morley My report will be a little briefer than in the past. I'll start out with four acute care hospitals and two long term care nursing homes in Western New York notified us, the department, that a strike vote had taken place in mid September, raising some significant concerns and a great deal of effort came into the department to work in support as this was developing. We're happy to report that a tentative agreement has been signed by the two unions, Communication Workers of America and 1199. That needs to be ratified and will be ratified, we hope, in mid-October. Survey Activity OPCHSM has conducted thirty-one surveys of hospitals end stage renal disease providers over the month of August. That's the most recent reporting month. Electronic survey update. The department continues its five days a week collection of data from hospitals regarding COVID, its activity and capacity. We've seen a growing trend of COVID hospitalizations, unfortunately, and you've heard that. We also conducted a one time survey looking at obstetrics services in the state. We're reviewing that data right now. The Safe Nurse Staffing Act that was passed a year ago. We've been working intensely on the committees that have come out of that statute. Additional information on this statute will be provided towards the end of the meeting. The Bureau of Emergency Medical Services. On September the 20th, the department's Bureau of EMS and State Trauma Systems convened families, friends and colleagues to honor members of the EMS community who had passed in the line of duty. Ten heroes names were added to the Tree of Life in Albany. The State Emergency Medical Advisory Council meeting took place. There was extensive discussion about the increasing volume of extended offload delays in hospital ER's around the state. The state EMS Council leadership has raised this issue to the attention of the department, and additional response will be forthcoming. The Bureau of Narcotic Enforcement. The drug takeback program continues to roll out statewide, with collection receptacles now available in over 1,300 pharmacies so far to which New Yorkers have returned 19,000 pounds of pharmaceutical waste. Additional pharmacies are offering collection receptacles and mailed back envelopes by the day. The Center for Health Care Policy. The 2023 legislature elected the New York State budget includes an appropriation for 2.5 Million for the Nurses Across New York program that will provide loan repayment for registered nurses and licensed practical nurses who make an obligation to work for three years in an underserved area. The legislation includes a provision that the Department of Health shall appoint a stakeholder work group to develop recommendations and to implement any nanny recommendations by September. The work group is comprised of associations representing nurses, general hospitals, long term care and other health care facilities and includes representatives from twenty organizations. The work group met in July, August and September and developed recommendations. A report has been forwarded to the Governor's office. The definition of underserved areas, award amounts and hardships may need to be considered if a nurse cannot fulfill the three year obligation. We're currently drafting a solicitation of interest and hope to have it finalized by the end of November and

out for public consumption. In response to concerns that have been raised in the past sessions related to primary care in the pandemic and public health emergencies, I'd like to thank our policy office folks for helping to construct the response to the committee related to primary care and the pandemic. The Article 28 of the Public Health Law gives the Department direct regulatory oversight over hospitals, including general hospitals, residential health care facilities and diagnostic and treatment centers, including many but not all of FQHC's. There is not a similar corresponding article within public health that pertains to private medical practices. As such, the department are statutorily limited in their response to implement surge and flex operations at settings outside of Article 28 institutions. In addition to the legal limitations, state resources would be necessary to monitor the implementation of surge and flex operations and to assist in operations such as helping to divert patients. Based on the department's past experience in employing surge and flex operations, the department believes in an estate disaster emergency that impacts the health care delivery system. Focusing surgeon flex operations in acute care settings most efficiently uses such limited resources. Nevertheless, the amendments to Title 10 of the New York Codes and Rules and Regulations Surge and Flex Care Coordination System are not specific to general hospitals, but do cover regulated, quote, health care facilities, end quote. Accordingly, if resources allow and the public health emergency demands it, the Commissioner would have discretion to implement surge and flex operations in DNTC's, including those of FQHC's that fall under Article 28. Finally, I should note that regulations are identical to the Emergency Surge and Flex regulations were published in the State Register as a proposed regulation. The public comment period closed on Article 28. There weren't any comments related to Surge and Flex outside of Article 28 facilities in those comments.

Dr. Morley That's my report, Mr. Chairman.

Dr. Morley If you've got any questions, I'd be happy to take them.

Dr. Morley Thank you.

Mr. Kraut Thanks so much, Dr. Morley.

Mr. Kraut I'll open up the questions.

Mr. Kraut Dr. Berliner first, then Dr. Boufford.

Dr. Berliner Thank you, Dr. Morley.

Dr. Morley I'm struggling to hear you.

Dr. Berliner Can we get a report on the status of freestanding emergency rooms around the state?

Dr. Morley We can and we would be willing to talk to you offline just to collect more idea of what it is you're looking for. Is it just a number or more than that?

Mr. Kraut When we approved the development of freestanding emergency departments through CON, when they had a requirement to file an annual report and we laid out the data that they were required to report back to us. Our understanding is everybody has filed those reports and they just need to be kind of coalesced into this is our impression of what has happened and what the benefits and what are the challenges. I think we'll take it

offline, but a lot of the work has supposedly been done already by applicants, but not necessarily has it been reported back to us. We'll follow that up with you.

Mr. Kraut Now, we'll turn it to Dr. Boufford.

Dr. Boufford Thanks. Dr. Morley.

Dr. Boufford I appreciate your responding to our expressed concern several times about the failure to include broader primary care providers and local health departments in this sort of response, initial response to COVID and in surge and flex regulations that were promulgated which largely really focused on acute care hospitals. I appreciate the legal constraints that you lay out, and that's very helpful to know. It's very important to know. I think the primary concern, which I still have, is that the primary care providers that you legally, let's say that way, legally have authority over as well as local health departments. Really, there has been no vehicle for engaging them in conversation around the preparation for a regular vehicle. Let's talk about the rebuild. The revision of the COVID response. That remains the problem from what we know from what we've been told. I would say that you've certainly helped explain the limitations in the surge and flex regulations up to now. Now, with that understood, I think it would be really important to think about how there might be a convening to begin to look at the implications of the current surge and flex for community health centres and local health departments that do come under the auspices because the issue was people feeling they could have done more. This council put together a paper about two years ago with a number of sessions sort of laying out the thinking about that. Very much wish to be more helpful and more directly involved in future response to future pandemics. I think that's pretty hard to do unless you're prepared for that. The current surge and flex does a really great job of sending signals and preparing the acute hospital industry and their links for the next round, but not addressing the primary care and the local health department participation and the way that we had envisioned. I just want to say that. I hope we can continue getting something going in that space. The second thing I wanted to ask that I had mentioned this, I think at the last council meeting. If we can't do it today, because I know we have a lot of reports, but certainly for the next time. I think we had been interested in knowing what the current language was that linked the prevention agenda to the CON process for acute hospitals. The council had been on the record before COVID, really wanting to see that and wanting to see conversations about the extension of that, of linking to the prevention agenda, to certificates of need. As you pointed out, there are some limits to that. Again, moving beyond acute care hospitals and in view of the fact that for the last couple of rounds, there have been some hospitals that have really indicated they've not made any participation in the prevention agenda in their application and others indicating they've not invested in that process. Again, may I ask the next time we hear about that. I'd love to perhaps have some thoughts from you all about how do we moving forward involve other than the acute hospitals in planning for the next surge and flex or the next epidemic now rather than scrambling at the last minute.

Dr. Boufford Thank you.

Dr. Morley We're certainly more than interested in continuing the discussion, in the dialogue as to what else can be done. I have to apologize. I'm embarrassed. I was provided information that I didn't include in this report. It was an oversight on my part. It was to include the questions that were asked in the CON as it relates to that agenda. I promise you we will have it in the next report. You know that this is something that we're interested in continuing the dialogue on. You also heard you mentioned local health

departments. Dr. Bauer on the public health side has got that up and running full bore. The commissioners attendance at those meetings is certainly something that's going to trigger and stimulate additional discussion about their role in this. We do want to be on the same page with those folks and we recognize that they have a lot to contribute.

Mr. Kraut Mr. Robinson, then Mr. Lawrence.

Mr. Robinson Thank you, Mr. Kraut.

Mr. Robinson It wasn't coming through.

Mr. Robinson Is it coming through now?

Mr. Robinson Which is that as we look at trying to recover the health system broadly from the loss of staff and the other struggles that came about as a result of going through the pandemic. It is clear to us that the key to sort of unlocking this and moving it forward is actually resolving issues relating to long term care. The importance of the state making strategic investments both in workforce and regulatory flexibility and reimbursement in the long term care sector. Right now, hospitals and emergency departments across the state are backed up. A lot of that back up is due to the fact that nursing homes can't accept transfers of alternate level of care patients who need to be in nursing homes to nursing homes. We think that should be a budget priority specifically for the Medicaid program for this coming year in order to start to rebalance the health system and ensure that people who need access to hospitals, emergency rooms and other health care settings are able to get it. That particular issue to our way of thinking, is the biggest block. I'm bringing this up not in response to your report, but more because of the fact that the budget process is now underway in the executive branch. This is the time for you and the other members of the Health Department to consider your input to that process.

Mr. Robinson Thank you.

Mr. Kraut Mr. Lawrence.

Mr. Lawrence Thank you, Dr. Morley, for addressing in outlining the legal structure for FQHC's and for other providers to be involved with the surge and flex. I think one of the things that at least has been articulated over time is that we did not want to have a health care system where people were operating in silos that the best care for New Yorkers or care where there's an integrated approach to the delivery of services, especially in neighborhoods that are underserved. I believe in many of those neighborhoods, the primary go to place for services often are community health centers across the state. One of the things that I would like to ask is, do we have a sense for what is happening with primary care? I've heard a number of and seen a number of reports where it's felt that the primary care is inadequately funded across the state and that really going into the next year and the year after that, there's going to be a bunch of hurt and pain emanating from primary care providers. They are dealing with a cost structure that has been impacted as all others have been impacted by COVID in terms of the labor force and other costs that have gone up. I guess what I'm trying to get to is, could the department really do an assessment on what's happening in primary care so that we understand where we are with that critical element and provider in the delivery system, especially in underserved neighborhoods. I think that's critically important to have such an assessment and also to understand the critical role that primary care providers played throughout the pandemic, first doing testing and then administration of vaccines, in addition to all of the other work

that we do in terms of chronic disease and just wellness work. I don't know whether this is the forum to request that, but I think it is critically important that we have such an assessment and we know what is happening with a key component of our system.

Mr. Kraut Well, Dr. Morley, it's fortuitous that Ms. Morne is to your right, because the two of you will be attached to the hip on those issues. Because they do overlap, if you think about it substantially.

Mr. Kraut Mr. Thomas and then I just don't want to lose a quorum, because we have to take some votes. We have another speaker. I just want to keep making sure.

Mr. Thomas Hugh Thomas, member of the council. This is directed both Dr. Morley and Commissioner Herbst. I want to just enthusiastically second Mr. Robinson's comments about the state of throughput and long term care and its effect on acute care facilities. Dr. Morley, thank you to the Department for reaching out directly to the region during the conversations. It's great news to hear that there's a tentative vote. Obviously, our system and Mr. Robinson system would have been impacted by that. The department is in constant project with us, so we appreciate it. Commissioner Herbst, just for you in particular, I think the number in our region is 1,300 nursing home beds off line. All the acute care facilities are backing up. That's actually regional. I heard from New Jersey, Connecticut and Downstate last week similar problems. Very specifically would urge you and you don't have to respond today, Commissioner, but the program, we have a couple of very specific and important facilities in our region that have requests in and I understand that there's a process and that there's not limit the least amount of funding. I understand the challenge, but I would urge you to look carefully at that in the context of really what is a just a stock throughput process pretty much all over, maybe not so much Downstate, but certainly in our region. I would urge you to take a look at those applications as you can, and hopefully we'll have an announcement in terms of your intent to distribute those funds in the coming weeks.

Mr. Thomas Thank you.

Mr. Kraut Thank you, Dr. Morley.

Mr. Kraut That's a nice introduction to Mr. Herbst, who, as you know, has recently, as part of the reorganization of some of the department's activity, is heading up the Office of Ageing and Long Term Care. We've asked him today to kind of give us an overview of the organization of that office and some of its agenda items and priorities.

Mr. Kraut Mr. Herbst.

Mr. Herbst Good morning. I guess it's good afternoon now. I'm pleased to be back with you all for today's conversation. I would like to give some background on our new office and I would also like to provide some updates on a handful of projects before I finish today. As you've now heard a few times in late July, early August, our department set forth some important priorities and reorganized the way we work to better serve New Yorkers. One of those priorities was the creation of the Office of Aging and Long Term Care, or OALTC, another acronym that the department will be putting into place. We're focused on optimizing the department's talent and the integration of new systems and increasing diversity as part of our overall mission to build a healthier, more equitable New York. OALTC will be dedicated to the needs of aging and disabled New Yorkers. I hope this new office will help to ensure aging New Yorkers have greater access not only to essential

health services, but to appropriate living settings and programs that reduce isolation. The vision we have for this office and our mission is to foster policy and programs and services that meet the health and long term care needs of all New Yorkers. This includes support to those who seek to age in place, as well as people who choose long term care in nursing facilities. We have an urgency to our mission. New York is already home to the fourth largest population of residents over the age of 65. Almost 20% of the entire state. In the coming decade, we are facing a tidal wave of aging New Yorkers. By 2030, a quarter of our state's population is projected to be over 60. As many of our aging baby boomers will seek the care and security of nursing homes or adult care facilities. There is also nearly 100,000 New Yorkers residing in nursing home facilities and hundreds of thousands receiving home care. Long term care spending accounts for nearly 35% of the total state's Medicaid spending, and that's the state's largest cost driver. We can see this wave approaching and the necessity of our work. We need to shore up our support for New York's most vulnerable population, as Dr. Bassett referred to it earlier. Establishing this new Office of Aging and long term care is an important first step to align the department's expertise and resources for greater impact not only for aging and disabled New Yorkers, but also for the families and stakeholders and advocates upon who we all rely on. OALTC will be responsible for data management and licensing and surveillance policy and finance, as well as communication programs to help educate and build consensus. We'll also weave in programming to address our mission to improve public health and health equity and address the social determinants of health such as transportation, housing and nutrition. By placing the manifold of issues surrounding long term care under one roof, we're not just elevating the issue, but we're giving the new office the overall resources that we need and the power to build a network with one aim. Again, this is to help serve aging New Yorkers and those who seek long term care facilities. One of our most important priorities is to ensure New Yorkers can age in place for as long as possible with dignity and independence and have access to quality care when they need it. The same holds true for all New Yorkers with disabilities. Both those people who need short term rehabilitation and those who require long term care or need additional supports to live meaningful lives in the community. In addition, I referred to the Governor's proposed master plan for aging, which will lay the foundation for us to change the landscape of aging and long term care in our state. A foundation that's designed to enforce the long term care community for the long haul. The master plan will probably be inclusive, focusing on age friendly health systems and public health initiatives. Again, such as housing and transportation, community engagement, rural challenges and telehealth and digital strategies for social engagement. We'll measure outcomes, but most importantly, we'll rely on equity as a driving factor in the master plan. We'll aim to open up alternatives to nursing homes and facility based care and will convene with the efforts of the public and the private sector to convene and create communities that promote healthy living and civic engagement. We also want to look at other ideas, such as walkable communities that promote exercise and reliance less on vehicles. OALTC will spearhead the implementation and the execution of the master plan. We'll focus on creating a blueprint together for strategies for government and the private sector and the not for profit sector to support older New Yorkers. We'll ensure the state has policy and programs and they're coordinated in aligned line to ensure New Yorkers can age in our state with freedom and dignity and independence for as long as possible. The master plan is a response to the approaching wave that I mentioned earlier. The actions we're taking now will help us prepare for the challenges ahead. We cannot do this alone. There's already been so much expertise coalescing around the master plan. We're grateful for the inputs from stakeholders and advocates and organizations and welcome insights to continue from all areas across the long term care ecosystem. We'll certainly rely on the partnership of you as a partner in addressing the health and long term care needs of aging New Yorkers as

well. I look forward to keeping all channels of communication open with you as we build a more sustainable and integrated system of care. This includes the areas of the the mission from the role of the Ad Hoc Committee to the State Health Improvement Plan, known as the Prevention Agenda that we've spoken about a handful of times already today to the work done in committees and public health discussions, debate on the Committee of Health Planning and the Committee on Codes and Regulations and Legislation, as well as the activities related to the licensure and construction process completed. I'd like to now move and give some quick updates on six areas that OALTC has already initiated. First, was the reform of various need methodologies. One of the major areas that OALTC has committed to is changing outdated and restrictive need methodologies, especially in Article 36 and Article 40 hospices. Determining public need is crucial for thoughtful health care planning. However, determining public need should serve to strengthen and not hinder the establishment of new facilities and home care services in areas underserved. This must change, and it will. OALTC is now working on improving and streamlining the need methodologies to reflect our current ecosystem. OALTC looks forward to working with you on important issues and welcomes feedback and suggestions as we move forward. Second is a lifting of the moratorium. As you're aware, the department recently released the new licensure application process in mid-August. As a result of this new application release, we anticipate a steady increase in the number of applications that you will be asked to review and approve. Again, OALTC looks forward to working with EPRC and the entire membership as we move forward with increasing access to home and community based services. This must be done responsibly and in a reasonable manner that ensures high quality health care for New Yorkers in need of home health services. Third is the critical nursing home quality work. I'm fully aware that for many years you have led the public discussion on the important question of what nursing home quality should mean. Nursing home operators should be held responsible and accountable to the residents of New York's nursing homes and the families who entrust their loved one's care to these providers. We are committed to this important issue and over the next year we'll work to strengthen quality in nursing homes through the New York State legislative and regulatory processes, the executive budget and also thoughtful policy development. We'll look forward to your support and input. Again, we look forward to partnering with you as we not only look to improve the quality of nursing homes, but to do so in an efficient and timely manner. Fourth is the issues related to workforce. The issues of workforce are a major issue and must be addressed by all health care stakeholders. OALTC has listened to members ask the fundamental question, How should the department consider the quality of CON applications when it comes to workforce considerations, especially when reviewing patient volume projections? Even if an applicant can meet their expected patient volume projections, how will these applicants find and retain qualified staff? These are important threshold questions. They'll be asked to consider by the Department on all CON applications moving forward. OALTC looks forward to working with you in finding common sense approaches to this crucial and growing problem. Fifth is the reform. Earlier this year, you heard from Brett Friedman, the former New York state Medicaid Director, as he provided an in-depth presentation on the structural alternatives for the program of all inclusive care for the elderly, also known as PACE. OALTC remains committed to working with OHIP and all our external stakeholders and you of reviewing ways to improve the states ability to reform the PACE program to promote expansion of this innovative model. OALTC is in the process now working towards that goal by analyzing ways to implement and improve the PACE program. As mentioned at the presentation, the legislature has passed a bill earlier this year to establish a combined licensure and surveillance process for the PACE program. We look forward to keeping you informed as discussions progress on this legislation. You will be actively engaged in any policy discussion and regulations adopted to implement this legislative initiative. Sixth, and finally is streamlining the way we

conduct business. We've heard the concern raised by members, and we're eagerly looking for new ways to address your concerns. Specifically, I'm referring to at the last meeting you asked, how can we streamline processes to ensure that you thoroughly review and consider the most important matters related to CON and establishment and construction applications and remove matters of important but at times ministerial implication from your busy and full agendas. As a follow up to this question, I have OALTC staff now looking for better ways of reforming our work in the upcoming cycle, and I'll have more comment on this with different solutions very soon and look forward to further conversation with each of you at the upcoming meetings. Once again, we believe is a vital partner in working with the department on Health Care Policy and OALTC wants to engage with you in discussing the prevention agenda that Dr. Bassett has discussed now, and to work closely with all of our committees and get your input and final approval. It will help lessen the need to overstretch the indispensable time that uses at these meetings and discuss aging and long term care projects and concerns. I hope that OALTC will continue to foster community within this critical industry. We need to keep all channels of communication open as we build a more sustainable, integrated system of care. The work ahead of us is certainly expansive and critical for all aging New Yorkers. During the next few weeks, the OALTC team and I will reach out to each of you to discuss ways we can improve upon our work in these areas and get your feedback and ideas. I also look forward to being present at any committee and presentations to provide more detail as you may deem important for the aging and long term care sector.

Mr. Herbst Thank you.

Mr. Herbst I welcome any comments or questions you may have.

Mr. Kraut Thank you, Mr. Herbst, for that great overview. Again, it's a packed agenda. You'll find a very, I think, engaged and meaningful partner on many of the items you raised.

Mr. Kraut Does anybody have any questions?

Mr. Kraut I'll start with Mr. La Rue, go to Dr. Boufford then, Ms. Monroe.

Mr. La Rue Good afternoon. Thank you for the presentation. I don't have a specific question. I just want to acknowledge and share our appreciation with the department for the way it's been reorganized in creating this focus on long term care. It's something that the group here has been discussing for a number of years. We're really excited that you're leading this effort. We look forward to working with you to improve the life of older New Yorkers.

Mr. Herbst Thank you very much.

Dr. Boufford As I say formally, I'll associate myself with Mr. La Rue's comments. Really terrific intervention also, in your holistic view. I just want to make two comments. One, you referred to the prevention agenda several times, which is terrific. One thing that I think we sometimes forget about it there are objectives for older persons in each of the overall goals of the prevention agenda. This was a long conversation that we had in creating the latest version of the prevention agendas, rather than having an isolated goal for aging or for older people, we would embedded in each of the five goals. It'll be great to really look specifically at that in relation to the priorities set by local communities for the areas they're going to work on. The other thing is a friendly amendment to the name of your office,

which would be to call it the Office of Healthy Aging and Long Term Care. I think you could still say OAL, because O would be OH, right? ALTC. I wanted to put that on the possibility range early on in your existence.

Mr. Kraut She just wants to get to you before you order the T-shirts.

Mr. Herbst I think the mugs and pencils have been ordered.

Mr. Kraut Ms. Monroe.

Ms. Monroe Yes.

Ms. Monroe Thank you very much.

Ms. Monroe I really like the way you've structured the six areas. Each one of them cries out for data. That means baselines and goals and progress. I think if you can work with us to incorporate that kind of data into the work that we're doing, I think we'll be far ahead. Very often we're talking in general terms or we're given numbers verbally, and it's hard to contain all of those. I'd like to see you develop almost a dashboard that could be reported on that has, as I said, baseline and progress and goals that we could look at every time as a dashboard, but maybe spend our time on the two or three things that emerge from the dashboard as most important to discuss. Again, thank you for the work you're doing. I think we all look forward to real progress on these issues.

Mr. Herbst Thank you.

Mr. Kraut Thank you, Mr. Herbst, so much for again, for the report.

Mr. Kraut I'm now going to ask Mr. Holt, which I had jumped to right away when I started the meeting. I guess I just didn't want to lose the ability to have a quorum for a vote. Please give us the report on Codes, Regulations and Legislation.

Mr. Holt Thank you, Mr. Kraut.

Mr. Holt I will note that when I originally spoke, I said good morning and I will now be able to say good afternoon.

Mr. Kraut As long as you don't say good night.

Mr. Holt At today's meeting of the Committee on Codes, Regulations and Legislation, the committee reviewed and voted to recommend adoption of the following emergency regulations for approval to the full council. The first being the investigation of communicable disease. Staff from the department presented the Regulation to the Committee on Codes and are available to the council should there be any questions of the members.

Mr. Holt I move to accept this regulation.

Mr. Kraut I have a motion from Mr. Holt. I have a second by Dr. Gutierrez.

Mr. Kraut Are there any questions from the council?

Mr. Kraut I'll call for a vote.

Mr. Kraut All those in favor?

All Aye.

Mr. Kraut Dr. Watkins as well.

Mr. Kraut Opposed?

Mr. Kraut Abstentions?

Mr. Kraut The motion carries.

Mr. Holt Second regulation presented by the department staff was regarding face coverings for COVID-19 prevention. Staff are available should there be any questions.

Mr. Holt Otherwise I so move the adoption of this regulation.

Mr. Kraut I have a motion from Mr. Holt. I have a second by Dr. Gutierrez.

Mr. Kraut Are there any questions or comments from the council?

Mr. Kraut All those in favor?

All Aye.

Mr. Kraut Dr. Watkins also voted yes.

Mr. Kraut Opposed?

Mr. Kraut Abstentions?

Mr. Kraut The motion carries.

Mr. Holt The last regulation that we consider related to monkeypox virus, adding it to the list of sexually transmitted disease. Staff presented to the committee and they're available should there be any questions.

Mr. Holt Otherwise, I so move the adoption of this regulation.

Mr. Kraut Thank you much.

Mr. Kraut I have a motion from Mr. Holt. I have a second by Dr. Gutierrez.

Mr. Kraut Are there any additional questions or comments by the counsel?

Mr. Kraut All those in favor?

All Aye.

Mr. Kraut All those opposed?

Mr. Kraut Abstentions?

Mr. Kraut Dr. Watkins voted yes in Albany.

Mr. Kraut The motion passes.

Mr. Holt Mr. Chairman, this completes my report.

Mr. Kraut Mr. Holt, thank you very much. Thank you very much for running a wonderful meeting this morning. We deeply appreciate it.

Mr. Kraut I'm now going to turn to Dr. Kalkut to give the report on the actions of the Establishment and the Project Review Committee.

Dr. Kalkut We will start with 2 2 1 2 1 8 C, United Memorial Medical Center in Genesee County. There's a conflict and recusal by Mr. Thomas who's left the room. This is to certify a new extension clinic at 8103 Oak Orchard Road in Batavia, providing primary care, other medical specialties and a single specialty ambulatory surgery center services, gastroenterology. The department and the committee both voted for approval with contentions and contingencies.

Dr. Kalkut I so move.

Mr. Kraut I have a motion by Dr. Kalkut, second by Dr. Gutierrez.

Mr. Kraut Are there any questions on this application?

Mr. Kraut All those in favor?

All Aye.

Mr. Kraut Opposed?

Mr. Kraut Abstentions?

Mr. Kraut The motion carries.

Dr. Kalkut Our next is a set of applications that we're going to bundle. I believe there's ten applications in here. I will go through them. First is 2 2 1 1 9 9 B, Health Inc. in Kings County. This is to establish and construct a new diagnosis and treatment center at 1663rd Street, Brooklyn, to provide primary care and other medical specialty services. Both the department and the committee recommend approval with conditions and contingencies. 2 2 1 2 1 2 E, Smile New York Outreach LLC in Bronx County. This is to transfer 100% of ownership interest from one withdrawing member to a new member within the sole member LLC. Both the department and the committee recommend approval with a condition and a contingency. Next is a certificate of Debt Solution JGB Health Facilities Corporation. This request consents for filing to dissolve JGB Health Facilities Corp. Approval is recommended by both the department and the committee. 2 2 1 1 4 3 E, AMSC LLC doing business as Downtown Bronx ASC in Bronx County. This is to transfer 100% of membership interest in AMSC LLC doing business as Downtown Bronx ASC. The department and committee recommend approval with conditions and contingencies with

an expiration of the operating certificate three years from the date of the completion of the application. 2 2 1 0 9 5 B, Empire CSS LLC doing business as Empire Center for Special Surgery. This is to establish and construct a new Multispecialty Ambulatory Surgery Center at 4855 Hylan Boulevard in Staten Island. The department and the committee recommend approval with condition and contingencies with expiration of the operating certificate five years from the date of issuance. 2 2 1 2 2 4 E, 21 Reade Place ASC LLC doing business as Bridgeview Endoscopy in Dutchess County. This is to transfer 41.665% ownership to five new members of the sole member LLC. Recommendation from the department and the committee approval with a condition. 2 2 1 2 6 7 E, Advanced Endoscopy LLC, DBA Advanced Endoscopy Center in Bronx County. This is to transfer 10.71213% ownership from the three withdrawn Class B members to one new member LLC. The department and committee recommend approval with a condition. 2 2 1 2 7 0 E, Endoscopy Center of Niagara LLC in Niagara County. This is to transfer 49% ownership interest from one withdrawing Class A member LLC to two new Class A member LLC. The department and committee recommend approval with a condition. 2 2 1 2 7 1 E, Endoscopy Center of Western New York, LLC in Erie County. This is to transfer 100% ownership from fifteen withdrawing members to two new member LLC. The department and committee recommend approval with a condition. 2 2 E 2 7 2 E, Island Health Center in Suffolk County. This is to transfer 10% ownership interest from three withdrawing members to one new member LLC. The department and committee recommend approval with a condition.

Dr. Kalkut I so move.

Mr. Kraut I have a motion by Dr. Kalkut to move these applications. A second by Dr. Gutierrez.

Mr. Kraut Does anybody have a question on any one of the applications that have been placed in this batch?

Mr. Kraut Because you're just as a backup facility.

Mr. Kraut Thank you.

Mr. Kraut Dr. Strange will declare an interest of the Staten Island application.

Mr. Kraut If there's no other comments, 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.

Dr. Kalkut 2 2 1 2 6 8 E, Carnegie Hill Endoscopy, LLC in New York County. There's a conflict in recusal by Dr. Lim, who's left the room to transfer 18.66% ownership interest from three withdrawing Class B members to one new member LLC. The department and committee recommend approval with a condition. 2 2 1 2 6 9, East Side Endoscopy LLC

doing business as East Side Endoscopy and Pain Management Center in New York County. Again, a conflict and recusal by Dr. Lim, who was out of the room. This is to transfer 41.926 ownership interest from three withdrawing members to a new member LLC 83.3333% interest from two withdrawing members two existing members within two member LLC and 9.306 from an existing member to a new member within a member LLC. Department and committee recommend approval with a condition.

Dr. Kalkut I so move.

Mr. Kraut I have a motion by Dr. Kalkut. I have a second by Dr. Gutierrez. Dr. Lim has left the room.

Mr. Kraut Are any questions on these applications?

Mr. Kraut All those in favor?

All Aye.

Mr. Kraut Opposed?

Mr. Kraut Abstentions?

Mr. Kraut The motion carries.

Mr. Kraut Please ask Dr. Lim to enter the room and say goodbye to Mr. La Rue.

Mr. Kraut Are you declaring an interest?

Mr. Kraut Oh, because it says abstain.

Dr. Kalkut 2 2 1 1 8 4 E, Emerest Certified Home Health Care of New York LLC doing business as Royal Care Certified Home Health Care of New York. This is in Bronx County. This is to establish Emerest Certified Home Health Care of New York LLC as the new operative Cabrini Certified Home Health Agency, a certified home health agency currently operated by Cabrini of Westchester and relocated to 798 Southern Boulevard in the Bronx. The department and committee recommended approval with conditions and contingencies.

Dr. Kalkut I so move.

Mr. Kraut I have a motion. I have a second by Dr. Gutierrez.

Mr. Kraut Any discussion here?

Mr. Kraut Mr. La Rue.

Mr. La Rue I just want to clarify I abstained in the committee meeting.

Mr. Kraut I reread it wrong.

Mr. La Rue Thank you.

Mr. Kraut It's declaring an interest.

Mr. La Rue After consulting with counsel.

Mr. Kraut All those in favor?

All Aye.

Mr. Kraut Opposed?

Mr. Kraut The motion carries with an interest.

Mr. Kraut Thank you.

Dr. Kalkut That concludes the review. .

Mr. Kraut Thank you very much, Dr. Kalkut.

Mr. Kraut That concludes that report.

Mr. Kraut I'll now turn to Ms. Royal, who's going to give us an overview of the long term care ombudsman's office.

Mr. Kraut I'm assuming she's in Albany.

Ms. Royal I am.

Ms. Royal I'll try to be quick, cause I know we're several hours in. The goals for today would be to give you the mission and the values of the Long Term Care Ombudsman Program. We refer to it as LTCOP, another acronym. The administration and structure of the program.

Mr. Kraut I'm sorry. Could we please have the camera on Ms. Royal, because we can't see her.

Mr. Kraut Thank you.

Mr. Kraut Go ahead.

Ms. Royal That's okay.

Ms. Royal We wanted to talk about the roles and the responsibilities of a certified ombudsman, which is both paid staff and volunteers. Our role for the comments and the nursing home ownership and transfer or establishment process, which is essentially why we are here. Our program mission is to serve as an advocate and resource for older adults and persons with disabilities who live in long term care facilities. Anyone in any long term care facility is who we serve.

Ms. Royal Next slide.

Ms. Royal Sorry, I'm not telling you.

Ms. Royal Our program values, which the very main thing for this program is to be a resident centered focus.

Mr. Kraut I'm sorry, but the slides are not being advanced and we can't see them. You're just on the title page.

Ms. Royal Looks like they're working on it. I'll wait for them to catch up.

Mr. Kraut Just continue and we'll catch up.

Ms. Royal Okay.

Mr. Kraut That's fine.

Ms. Royal Our program values is primarily to be always resident centered focus. Everything that we do in this program is based on what a resident wants. We also have a primary goal to always maintain confidentiality. Anything a resident brings to us is confidential unless they give us permission to share that information. We're also trying to be accessible to residents. Our goal is to be available to residents when they need us. Prevention is another program value. We're working to prevent residents to ensure their rights are not violated and to be free of abuse, neglect and exploitation. Resident Empowerment and Autonomy. We're always looking to provide residents with tools to be as autonomous as possible so that they can advocate for themselves as well. Complaint resolution. Resolution is a key piece here because we're not looking to Band-Aid issues that they have. The goal is to have long term resolution to the issues that they may have to follow up and ensure those things are continued to be resolved and aren't popping up again. We're also having to be objective. This can be a difficult thing for an ombudsman, because what we may feel is in the best interest of a resident. They may want a totally different thing. We have to remain focused on what their goal is and to be objective and everything that we're doing for the residents. We wanted to give a basic overview of the administration of the program. The Older Americans Act, which is administered by the Administration on Community Living ACL, requires each state to establish an independent office of the state long term care ombudsman. In New York, we are administratively housed within the Office for the Aging and we provide advocacy services through a network of regional programs. At the state office, there there's myself as the state ombudsman who oversees the whole program. I have a senior assistant state ombudsman. We have three assistant state ombudsmen who supervise the regional programs. Across the state, we have fifteen regional programs and each of the assistant state ombudsman are assigned five to oversee. In each region there's a coordinator of that program and they're responsible for recruiting and training the volunteers throughout the state. They are responsible for being the regular presence in the nursing homes and adult care facilities that we serve. To be a certified ombudsman, there's a lot to do. You have to follow a thirty-six hour certification training. It's a very intense program talking about the roles and responsibilities of being an ombudsman. And then after your certification, training for all the years following that you have to now complete eighteen hours of continuing education throughout each program year. That's a requirement from ACL. Our volunteers commit two to four hours a week in their facilities that they're assigned to, to provide those advocacy services. The duties of an ombudsman are to identify, investigate and resolve complaints made by or on behalf of residents. We do work with families as well, but primarily they're on behalf of all residents. We inform residents about obtaining services from the program. When we're doing our regular visits and facilities, we would be providing residents with information on how to access us if they need us. We generally

touch base with any new residents that are coming into a facility so they're aware of our program. The facilities do have to provide information to all residents about the ombudsman program as well at least twice a year. We also represent residents interests before governmental agencies. With legislators, we advocate for things that residents are asking for us to work with them on. We work with our partner agencies throughout the state as well to improve the quality of care and quality of life for residents. We do promote and provide assistance to resident and family councils. We work with facilities that may not have a resident council to help develop one and help them facilitate those meetings as well as family councils. Especially since COVID, one of the positive things that came out of that was in some facilities being able to develop family councils through Zoom, so that allows more families to participate in those meetings and be more involved in the care of their loved ones. We do have access to all facilities and all residents at any time. We also have access to resident records as it relates to a complaint investigation that we may be working on. We can't have untethered access to a record, but if we're working on a specific complaint, we may access portions of that record. We are always to be provided with a list of the residents currently in the facility so that we can meet with new residents as they come in. Essentially, what is an ombudsman? We are an advocate for residents. That is the primary focus. We are an educator. We provide education to residents. We provide education to the community. We provide education to facilities staff and also families. We are a mediator at times for between a resident and possibly a roommate, their family, the facility. We may mediate issues to help resolve them for them. We're also a negotiator. Sometimes we have to negotiate with families, residents and facilities to try to come to an agreeable solution. Ultimately, we're a problem solver and an advocate for a resident. What we are not is a long term care facility regulator, a licensing surveyor, an inspector or investigator. We are not an adult protective services investigator. We are not a provider of direct care. We cannot provide any direct care to residents when we're in the facility by federal requirements. The last thing that we are not is a mandated reporter. That's important to know because that seems to be kind of contrary to our work, but we are not allowed to report any type of abuse or neglect without a resident's permission or their family if they are unable to do so or their guardian. We do encourage residents to report abuse. We may work on finding a solution to that in another way. We may talk with other residents. Ultimately, if the resident does not want us to report abuse, we're unable to do that. LTCOP and Department of Health have similar roles, but different. Both Department of Health and LTCOP oversight entities for long term care facilities. Department of Health looks more whether a facility is meeting regulatory standards and they have the ability to issue citations for non-compliance. We look at any expression of dissatisfaction that a resident may bring to us. We're looking for resolution to that at that time. We're not able to issue citations. We may file complaints on the things that we see, but we're not able to ultimately evaluate whether that meets the regulatory compliance. Department of Health andLTCOP both have presence in facilities, but those presents are different. Department of Health visits facilities for inspections, generally annual inspections or a complaint that they may receive. That would be the reasons generally that they're attending or visiting a facility. We visit more frequently. The purpose of our visits are to develop a rapport with residents and develop a trusting relationship with them, and also to develop a working relationship with the facility to help mediate the issues that residents may raise. We are there to provide education and information to residents, families and even facility staff while we're addressing concerns. We have more of a regular presence. Both agencies receive and investigate complaints, but we investigate differently. Department of Health is assessing the regulatory compliance. That is their role. We may be looking at more possible causes for a problem. We're trying to work with a facility to resolve that issue prior to it rising to the level of a regulatory need. We want to help a facility solve an issue before it has to escalate to the need to involve Department of Health. We do collaborate with

Department of Health. We have a good working relationship. We now have a dedicated online complaint form for the Ombudsman programs to file complaints with Department of Health and also a dedicated hotline number to Department of Health to file our complaints. We are also involved in Department of Health's annual inspection survey and exit conference. We know when they're there to visit a facility for a survey. We are able to attend the exit conference and provide information to Department of Health. We also have relationships at the regional level. Our regional offices from the Office and Program of Department of Health may reach out to each other with questions, you know, inform them of things that may be happening in a facility that we're able to that's not resident specific. We also work at the state level, the State Department of Health, the central office and us. We have a conversation fairly regularly, just to keep each other updated and share information. There is a collaboration between the two agencies. The ultimate goal, to improve the lives and ensure the quality of care for residents. The LTCOP recommendations, which is mainly the reason that we're here, is part of Chapter 141 of the laws of 2021, where the long term care program would comment on any ownership, transfers or establishment of new facilities. We wanted to give you some information on how we come to those comments, because our role isn't enforcement, our role is very different. We have different avenues of how we develop our comments. All at the beginning, Department of Health will inform us of any applications for ownership, transfer or establishment. We review those applications. We're focusing on the facilities that are currently owned or operated by proposed owners. That's inclusive of adult care facilities. If a proposed owner does also have stake in a adult care facility, we're going to look at our information related to that adult care facility as well. We review our data in our data system related to how many complaints they may have had, how many visits we've had to that facility in the past three years. We look at what types of complaints those are. Are we visiting on a routine basis? We also look at if there's abuse complaints. We would be really focusing on those if there's frequent abuse complaints in those facilities. We have calls with our regional programs to gather the overall information on a facility. While they're doing those routine visits we want to know, do the residents appear to be; comfortable, happy? Their conversations with them. Do they feel that the residents are accepting of the facility and how it's managed? We talk to the resident counsels. What type of input we get from the resident counsels and what types of complaints that the resident counsel may bring to us. We ask about what type of relationship the facility administration has with the long term care ombudsman program. If we're bringing them an issue, are they willing to work with us to try to resolve that for a resident, or is it an adversarial relationship? We ask about activities. What types of activities the residents have available? Do they seem to attend them? We ask about food issues. Food is a big thing in facilities. I mean, that's a key piece to some residents lives is their meals. We ask about those types of things. Also the cleanliness of the facility or the structure of the facility. Are their concerns with how it's being taken care of? We take into consideration a whole lot of observations, interactions and the actual data and complaints that we see before we make our recommendation. Ultimately, once that's been decided upon with gathering all that information, we submit our recommendation to you to review our recommendation. I attend the council meetings as well.

Ms. Royal And that is it.

Ms. Royal Thank you for giving me the opportunity to provide you with some information.

Mr. Kraut Ms. Royal, thank you so much for that. That was a very cogent and clear explanation of the office. We're really looking forward, as you outlined, you have a role to play in our review. We're particularly interested as it applies to the character and

competence of operating the facilities to focus it, you know, and that, you know, every place has issues that they need to address. Hopefully you and your colleagues are great mediators to make sure individual ones. We're particularly looking at patterns. We want to look at, you know, it has to rise to something that's substantive, that's documented, and it's just not one and dones. We think that it's a welcome addition of information that we believe is critical in evaluating candidates of competence and character to operate these facilities.

Mr. Kraut Thank you very much.

Mr. Kraut Unless there's something burning, I just I see I'm losing the room. I have one other presentation. I'd really like to get to it. Unless anybody has any questions for Ms. Royal, I'll hold off.

Mr. Kraut Thank you so much.

Mr. Kraut I appreciate it.

Ms. Royal Thank you.

Mr. Kraut Thank you.

Mr. Kraut Now, I'll turn the mic over to Mr. Hennessey and Ms. Shulman, who is going to give us a overview of clinical staffing.

Mr. Hennessey Thank you very much.

Mr. Hennessey My name is Mark Hennessey. I'm the Director at the Center for Health Care Provider Services and Oversight.

Mr. Kraut Just pull it a little closer.

Mr. Hennessey Try to talk as quick as I can.

Mr. Hennessey We're here today to talk to you a little bit about safe staffing standards for hospitals. There's two different laws that deal with safe staffing. One deals with hospitals, the other one deals with nursing homes. Today, we're specifically only talking about hospitals.

Mr. Hennessey Could have the next slide, please.

Mr. Hennessey The legislature worked on a law and passed that law. The law was signed on June of 2021. The law outlines a lot of the different lessons that were learned by facilities as well as by people that work in facilities during the pandemic. It really focuses on the idea of making sure that there's sufficient staffing to help reduce errors, complications, adverse patient care events and also support the idea of retaining skilled staff. We see a lot of information about those kinds of issues as we do work and investigations. This law really seems to amplify the idea of making sure that there's sufficient staffing to provide care to individuals who are in those facilities. There's also a couple of sections within the law that specifically talk about evidence based staffing standards. There's a little bit we're going to talk about later on about that. Also the importance of transparency. A lot of the data and information that's collected through this

process is actually available on the State Department of Health's website almost in real time from when we get it. There's a real emphasis on that as well.

Mr. Hennessey Go to the next slide, please.

Mr. Hennessey There's a couple of terms that exist within the law that we thought it was important to make sure that folks are aware of. General Hospital. Not going to reread the regulation, but this is the normal definition which is applicable to general hospitals. Within the law, there's the designation that each of the general hospitals is required to supply one of these safe staffing plans to the department. And then that safe staffing plan it's require that each of those safe staffing plans have a description of the patient care unit, which is a unit within that hospital that provides direct patient care. There's been some discussion on who is it applicable to? Who is not applicable to? The law is actually applicable to any of those patient care units. The last one and this is, I promise, the last definition we'll talk through here is ancillary members of the frontline team. These are folks who are not RN's, not LPN's, but a patient care technician, certified nursing assistants and other non-licensed staff who help with nursing or clinical tasks. You'll understand, in maybe a slider to why it's important for us to talk about that definition.

Mr. Hennessey If we could have the next slide, please.

Mr. Hennessey All of the hospitals were required to establish a clinical staffing committee. They were allowed to create those as new committees or assign the functions of a committee to an existing one. Specifically, in the cases where there is a collective bargaining agreement and it provides for a staffing committee that CBA is then going to really take the place of any of the rest of the structure that exists.

Mr. Hennessey Next slide, please.

Mr. Hennessey As I mentioned earlier, there's a real emphasis on making sure that the workers view is represented on those clinical staff and committees. At least half of the members are required to be registered nurses, LPN's or again, that term I talked about earlier, which is the AMFT's. They generally speaking, are people provide direct care to patients. They require that at least half of those members are people that fit that category, but then up to one half of the members are also selected by a general hospital administration. The Chief Financial Officer, the Chief Nursing Officer, directors of those patient care units are people that are mentioned specifically as folks who should be within this committee. In the case that there's no CBA, the members of the committee may be selected by their peers. How that selection takes place. If there is a CBA, there's a selection of RN's, LPN's and the AMFT's, according to the respected CBA. Another point that's raised is the importance of making sure that people who participate in these clinical staffing committees are given the opportunity to do so while being paid for their normal rate of pay. We have started to take receipt of some complaints in certain circumstances where there complaints that are raised about I wasn't allowed to go and work in the clinical staffing committee. We thought it was important to note that. And all of this, I should say, is really meant in part to you know, I don't think we've ever done a walk through of this new law. We want to make sure that you had more than just sort of the pencil sketch of things that you might otherwise get. Those clinical staffing committees are required to come up with that plan. They can do it in a number of different ways. They can use specific guidelines or ratios, matrixes or grids. When we've looked at some of the plans that have come in and we'll talk about how they come in a little bit, it has led to them looking a little bit different. The nice thing, again, is if you go on the department's website, you can look

at any of the plans that we've collected thus far. There are, I think, over 200 of them, but you will see that they look a little bit different in form of function because each of these hospitals is a little bit different. Those clinical staffing committees then are supposed to do a semi-annual review of the clinical staffing plan. The last piece is that they're supposed to review and respond to complaints as they come in and do an assessment. In circumstances where the department is going to do some work on one of those complaints or the plans, that kind of stuff, we may be working with the clinical staffing plan to get a greater understanding of what they know.

Mr. Hennessey Next slide, please.

Mr. Hennessey That Clinical Staffing committee adopts a clinical staffing plan. For each of those patient care units, there can be consensus that is reached where there's agreement on what those staffing levels should be. There can also be non consensus and in that case, the Chief Executive Officer is allowed to make a decision that's sort of a tiebreaker decision. When they submit those clinical staffing plans to us or the hospitals do, at that point it's really important for the CO in that case to designate to us and point out to us, here's the reason why we couldn't reach consensus.

Mr. Hennessey At this point, I'll hand it over to Stephanie Shulman, who's the Director of the Division of Hospitals Diagnostic Treatment Centers.

Ms. Shulman Let me talk to you about the rest of the clinical staffing.

Ms. Shulman Better?

Ms. Shulman Good.

Ms. Shulman I'm a little shorter than Mark.

Ms. Shulman Now, we'll talk a little bit about the implementation itself of the clinical staffing plans. Beginning on January 1st, 2023, and annually after that, hospitals are required to implement their clinical staffing plans that they adopted on July 1st of the previous calendar year. They also need to implement any subsequent amendments and assign personnel to each patient care unit in accordance with the plan. Under Public Health Law, 2805 T, each patient care unit within the hospital is required to have a separate clinical staffing plan. This plan needs to be posted so people in the hospital can see it and review it. It must include the actual daily staffing for that shift on that unit, as well as the relevant clinical staffing plan. Therefore, there will be some units that may not run three shifts and their clinical staffing plan would be reflective of that.

Ms. Shulman Next slide, please.

Ms. Shulman Regarding the annual clinical staffing plan submission. The plan is required to be submitted to the department by the Chief Executive Officer of the facility or their designee by July 1st of every year. It must be handed in. We will be reminding them if it's not handed in prior to that time. All data submitted must be accurate and needs to be compliant with Section 2805 T. If the adopted clinical staffing plan is amended, hospitals need to submit that to the department within thirty days of adoption. All of those clinical staffing plants, as described earlier, are posted on the department's website. When a staffing plan is amended, the previous one is taken down. The new amended staffing plan is put on the website. The statute is very specific regarding quality indicators, and these

include the number of RN's, LPN's and unlicensed personnel providing direct care. Those unlicensed personnel are really important, because they assist the professional staff in providing that level of care that the patient needs. This information must be expressed in actual numbers in terms of total hours of nursing care per patient. This includes adjustment for case mix and acuity. That's important because not every unit on the hospital is the same. As a percentage of patient care staff and must be broken down for total patient care staff for each unit and each shift. All of these methods for determining these clinical staffing plans need to be recorded and available to the department for review. Data regarding complaints, investigation of these complaints, findings as the result of the investigation and then degree of compliance must also be provided to the department.

Ms. Shulman Next slide, please.

Ms. Shulman There is an annual report requirement in the statute. The department is required to draft an annual report. This annual report does include the number of complaints submitted to the department, the outcome of these complaints, the number of investigations conducted and then the costs associated for these complaint investigations. The statute also requires a stakeholder work group. That workgroup is comprised of members of the hospital associations and the unions who represent nurses and the other ancillary members of the front line team. The stakeholder group will review that annual report prior to its submission. The department is required to finalize and submit an annual report by December 31st, 2022. That report is submitted to the Governor, the Speaker of the Assembly, the Temporary President of the Senate, and the Health Committee Chairs.

Ms. Shulman Next slide, please.

Ms. Shulman The statute also requires the development of an independent advisory committee. The Independent Advisory committee must consist of nine experts. Three of those experts are individuals who have knowledge and specialized in nursing practice, quality of nursing care or patient care standards. Three additional individuals are representatives of the unions who represent nurses. There's an additional three members who represent the general hospitals. This advisory committee is tasked with evaluating the effectiveness of the Clinical Staffing committee, review of the annual report and making recommendations to the Speaker of the Assembly, the temporary President of the Senate, and the Chairs of both of the Health Committees of the Assembly and the Senate.

Ms. Shulman Next slide, please.

Ms. Shulman Regarding the status of our deliverables, the annual report. We're currently collecting and compiling all complaints related to staffing submitted to the department and following up on those potential investigations. The statutory deadline for this is December 31st, 2022. We're also in the process of developing regulations regarding both the uniform collection of nursing quality indicators. We've already have reviewed some data collected as we described earlier. The staffing plans are currently posted on the department's website. We're making revisions to ensure that we have uniform data collection. We found in some of the plans that were received. Acronyms were used. We want these plans to be very comparable and very easy to be able to analyze and collate. We're working on all of that standardisation internally. The statutory deadline for that is also December 31st, 2022. Regarding the development of regulations, we're also working on the development of those, and that's a work in progress at this point in time.

Unidentified Speaker I'm just not sure if Dr. Morley's still on. I thought he might want to say something at the end of this.

Dr. Morley Still here.

Mr. Kraut Dr. Morley, would you like to add anything? Just because I'm going to lose the room in a little while.

Dr. Morley Into two seconds, I can tell you that it was our hope that we were going to be able to do some more on regulations, but this has been the statute. We've done it because, A, the statute was a long time ago, over a year. Two, it was complicated. Three, it was detailed. Negotiations are still taking place. Now, I have a high confidence level that we'll have regulations that we will review with you provide some education on at the December meeting.

Mr. Kraut Well, I think this is a critically important kind of background for that discussion. At least I'm glad you did it now, so we'll have some good sense of context.

Mr. Kraut I do want to open it up and take the opportunity, because what we don't want to do is you work on regulations, come back to us and then we start asking all kinds of questions.

Mr. Kraut If anybody has any comments. Remember, they have limited ability to ask very direct answers.

Mr. Thomas This statute is quite detailed as you both mentioned. Inside of it there is an enormous amount of discretion and definitional things. When you're talking about 24/7 365 operations in general hospitals of a varying acuity. I guess, my only comment would be as you're developing your regulations and I'm sure you're in communication with operations folks, you've got an independent committee that includes general hospital operators that you'd be really sensitive to potentially some unintended consequences as you develop your regulations. You don't have to comment now, but there's a whole I mean, we have eight hospitals in our system, so we're doing this and just the precision of the statute pretty good, but now the regulations could really enhance or really detract from the ultimate goal from our perspective. Just a request. No need to respond. I'm sure you're seeking input from a lot of people, a lot of people with interest in this. No lack of opinions, I'm sure.

Mr. Hennessey The only thing I will add because I think it's important. I think we're always open to listening to anyone who has a viewpoint on this topic and pretty much any other topic we work on. I will say that in the work that we've done thus far, we've received a lot of information back from hospitals that really has told the story of what you're just talking about, that there is a level of complication and a level of specialization that you see in different types of care, but specifically from hospital to hospital, hospital that makes a level of uniqueness that we're trying to harmonize a lot of different sort of capabilities to get to there.

Mr. Kraut I suspect that's going to be your major challenge is because just no two patient units are identical, as you said. No two hospitals in any particular area. It has to have flexibility with respect to situational awareness. Obviously, everybody wants to staff at an optimum level. But if you can't recruit that staff, as you heard your actually the colleagues from the Department of Health today acknowledge we're having issues Upstate in particular and frankly, throughout, you know, you can have a regulation, but if you can't

recruit and it's very clear given the environment of the reasons why we can't, we have to work on solutions that allow us to do that. And that's, frankly, a little outside of the statute of the regs. There's a lot of interconnect.

Mr. Hennessey Thank you for saying that, Mr. Kraut.

Mr. Hennessey That requires flexibility in terms of individuals, training, care plans, etc. In some point the statute, the language and your regulations are going to conflict and ultimately collide with reality. Reality is what Mr. Kraut just said. Now, hopefully it's a pendulum and it'll swing back and we won't be having this conversation in a couple of years. While you're developing your regulations, you're hearing that.

Mr. Kraut Dr. Boufford has one comment.

Dr. Boufford It's sort of a question. I think it was raised by the presentation. Many of these elements were part of the nurse staffing standards regs that you brought forward. This is really, really, really helpful. You raised two magic words, workforce and quality, which we don't talk much about. I was just curious as to using that and the workforce issues. Obviously, Dr. Gutierrez has been on this for the last four or five years. Where does the input to us from that? Do those two categories come from? Not these clinical standards, but looking I know they're part of the waiver budget implied. There would be investment in workforce and workforce development. We had a little bit on what's going on with the Public Health Fellowship. It wasn't exactly, you know, it's useful, but not in depth. The same thing on the quality side. Do we address those two issues? Are they sitting somewhere where we could at least have a presentation about them if they're not in our remit?

Mr. Kraut Just specifically, we've had discussions here about joining the Interstate Compact that allows us access to licensed personnel from other states. That obviously would be a major help in addressing some of these things. There are things that are outside of DOH and Department of Education, Licensing and the pipeline issues as well. They're not necessarily in the department's purview, but they're certainly related. It's a complicated enough issue as it is. You guys have a responsibility to kind of move this along and bring it back to us.

Mr. Kraut I'll give Dr. Gutierrez the final word.

Dr. Gutierrez Somebody who has been removed from the trenches of hospital work and clinical care for a long time now, I still hear the calls from the people that are still in the trenches of what they have to do and what they cannot do because they don't have the time. It's a request for flexibility and try to appear not draconian on this, because I don't think that unless you put that in front of you, you're not going to have a high level of success soon.

Mr. Kraut Let me put a pin in the conversation. You've heard flexibility is the key word when you bring it back to this council for approval and review. We wish you well. We're here to work with you. We understand what needs to be done. There's a time frame to get this started. Please, at our next so let me just use this. I want to remind everybody that the next meeting of the council is going to be--.

Mr. Kraut I'm sorry.

Mr. Kraut John, did you want to speak?

Dr. Morley That's okay. I just wanted to remind folks that the legislature did identify money. We are creating in OPCHSM, the Center for Workforce Innovation. We're in the process of hiring a director and then we'll be hiring about eight or nine folks. This will be a part of my report going forward.

Mr. Kraut Great.

Mr. Kraut That's what Dr. Boufford was saying. Where's the money?

Mr. Kraut The next meeting of the council is going to be on November 17th in Albany and New York City for committee day, and on December 8th in Albany and New York City for the council meeting. On the eighth in particular, please try to have your schedules, arrange it. It's in both places. Both here and New York City. We may need a little more time to go through an agenda. I particularly just want to thank Colleen Leonard and Michael and the rest of the staff. She's now operating out of two locations simultaneously dealing with things. As you saw this morning with the Codes Committee, with a number of people to speak, it's very, very complex. I just want to also thank Celeste Johnson who is our Associate Commissioner and Regional Director for the support in helping us down here in New York City in particular. We really thank you. We know how much harder this is. Hopefully, the legislature will revisit some of the Zoom options for public and open meetings.

Mr. Kraut With that, I have a motion to adjourn the Public Health and Health Planning Committee meeting.

Mr. Kraut So moved, Dr. Berliner.

Mr. Kraut Second.

Mr. Kraut We are adjourned.

Mr. Kraut Thank you so much.