NEW YORK STATE DEPARTMENT OF HEALTH
PUBLIC HEALTH AND HEALTH PLANNING COUNCIL
FULL COUNCIL COMMITTEE MEETING
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90 CHURCH STREET, 4TH FLOOR, CONFERENCE ROOMS 4A AND 4B, NYC
TRANSCRIPT

Mr. Kraut Good morning. I'm Jeff Kraut. I have the privilege to call to order the meeting of the annual Public Health meeting of the Health Planning Council. Welcome members, participants and observers. I want to remind you that there's an audience viewing this meeting via a webcast. For the public there's a form which you need to fill out to record your attendance in accordance with Executive Law Section 166, you will be able to get that form on www.NYHealth.Gov under Certificate of Need. You can email the completed forms back to Colleen Leonard at the Department of Health. We appreciate your support in having us comply here. Because we're subject to the Open Meeting Law we're broadcast over the internet. Please keep yourselves on mute if you're not speaking. Avoid the rustling of papers. Because we'll pick up everything, particularly side chatter. We're doing synchronized captioning. It's important that we don't speak over one another. The first time you speak, please state your name and briefly identify yourself as a council member or a member of the DOH staff. This will be helpful to the broadcasting company. I just want to remind everybody and encourage those of you who are interested in the work of the council to join the department's Certificate of Need listserv. We regularly send out important council information, notices, dates, agendas, and policy matters on that. There are printed instructions in the reference table on how to join. We also could do so online. Before I start today's meeting, I just want to welcome Dr. Fish. Although he's been here for the committee meetings his first full council meeting. As you know, Dr. Fish replaced Dr. Morley, who retired from state service back in December. Dr. Fish is going to be serving as the Deputy Commissioner for Primary Care and Health Systems Management. You may know Dr. Fish in his other hat is the Chief Medical officer for the Office of Health Insurance Programs and Infectious Disease Physician. He's been with the AIDS Center for the Department of Health Services at Albany Medical Center. Haad the direct delivery of care as a physician and the complexity of doing so within some of the larger providers within the state. Dr. Fish, we welcome you and look forward to working with you. I'm going to conduct the annual meeting first, which we'll vote on appointment of the council's Vice Chair. I will hear a full report from Dr. McDonald, Mr. Herbst, Dr. Bauer, Dr. Fish, Ms. Kim and doctors Boufford and Rugby will provide us updates of their committees. That will be followed by Mr. Holt, who will present the result of the Codes Committee. Finally, Mr. Robinson at the end project review. At the end of that discussion if you were able to stay around, I'd like to talk a little about the retreat that we have planned and some of the topics and ideas and how to structure the day and get some feedback. Just to remember that members of the council about conflicts. We've organized the agenda. Mr. Robinson is going to be batching CON applications. I hope you've taken the time to review the batch on the agenda. If there's any item that you want removed from a batch, please let Colleen know before we begin that consideration and Mr. Robinson gives his report.

Mr. Kraut I'm now going to open up the annual meeting portion of our meeting with the election of a Vice Chair.

Mr. Kraut I would move to elect the council's Vice Chair and to make a motion for Dr. Boufford to continue to serve as Vice Chair. I hope she accepts that honor.

Mr. Kraut You accept, right?

Dr. Boufford Yes.

Mr. Kraut May I have a second?

Mr. Kraut Dr. Berliner.

Mr. Kraut All those in favor?

All Aye.

Mr. Kraut Opposed?

Mr. Kraut Thank you.

(Clapping)

Mr. Kraut We are going to maintain our committee membership.

Mr. Kraut She calls every meeting and say, how's he feeling?

(Laughing)

Mr. Kraut We're going to maintain the standing and Ad Hoc Committees, roles, members of the same. We're hoping nominations to the council, as you know there's a couple of pending. I think that we'll revisit the committees and the membership once we are back up to full speed. For now, I think it's best if we just keep them the same. Establishment and Project Review Committee will continue to be Chaired by Mr. Robinson and Vice Chair Dr. Kalkut. Public Health by Dr. Boufford and Vice Chair Dr. Torres. Dr. Rugge will continue to Chair the Health Planning Committee and Ms. Monroe as the Vice Chair. The Committee on Codes, Regulation and Legislation will be Chaired by Dr. Holt and Vice Chair Dr. Yang. The Health Personnel and Professional Relations Committee will be chaired by Mr. Thomas. The Ad Hoc Committee to lead the State Health Improvement Plan Dr. Boufford. I want to thank all the members of the council for the work and dedication of the time you serve on this. It's extraordinary amount of information that we have to consume before each meeting. I know how much time that takes. Hopefully, as we've regained our momentum, I think coming out of COVID and we hope this year will be more productive year for us. There's a lot going on in the state in this exciting time, as you're going to hear a little later from the reports.

Mr. Kraut I'll call, the annual meeting to close.

Mr. Kraut I will open up our meeting of today's meeting.

Mr. Kraut May I have a motion to adopt the November 16th, 2023 PHHPC meeting minutes?

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

Mr. Kraut A second Dr. Torres.

Mr. Kraut All those in favor?

All Aye.

Mr. Kraut Opposed?

Mr. Kraut That passes.

Mr. Kraut It's my pleasure to invite Dr. McDonald, who is going to update the council about the department's activities since our last meeting.

Dr. McDonald Good morning, Mr. Kraut. It's great to be with you all this morning and joining you today from my office in Albany here at Corning Tower on the 14th floor. You know, as I start my comments, I just want to hope you'll join me in celebrating Black History Month. I'm reminded we all have a role together to implement policies and programs that really do what we can to strengthen health equity for all and eliminate barriers to improving health outcomes for Black New Yorkers. I'm just reflecting on how systemic racism has all too often played a role in reducing access to quality health care and contributing to inequitable health outcomes for communities of color. You know, under the leadership of Governor Hochul, the department will continue working to improve access to quality care and eliminating health disparities as we address the disproportionate impacts that preventable conditions such as maternal mortality, heart disease and diabetes continue to have on our Black community. I want to shift my conversation to cover some topics I covered during our budget hearing. I just want to make sure everybody's hearing sort of these same concepts here. One of the things that's interesting, I traveled a lot across the state this year. I did fifty-nine trips. Went to literally hundreds of community-based organizations, health care facilities, and literally met tens of thousands of people. The issue that really kept coming up every place I went to be the workforce issues. Sometimes I worry we're making this a little bit harder on ourselves then we need to. I sometimes think in New York we're playing soccer uphill when it comes to issues like scope of practice. One of the things I've just noticed is we're different than other states in some areas. I hope this year during the legislative and budget process we can make some of those changes. It's not lost on me that we're one of only eleven states that hasn't joined the Interstate Physician License Compact. We're one of only nine states that hasn't joined the Nurse Licensure Compact. These are in the budget this year as a policy issue. Hopefully, we'll get some traction on those this year. There's also some legislation that came forward this year just to help our health care workers do work they're already trained to do. Just a few examples like certified medication aides. Twenty-four states have allowed them to administer basic medications in long term care settings. I know there's support for that among a lot of our constituents. The other thing I think about is our physician assistant community, the PAs, for example. There are certain settings where after suitable training they could practice independently. Primary care and hospitals are just a couple examples. Another thought that comes to mind is just medical assistance. Forty-nine states allow a medical assistant to give a vaccine. We're the only state that hasn't done that yet. These are just a few examples of where I think we can do some things just to help it a little bit easier for our health care workers to actually practice things that they're already trained to do. I'm going to shift my conversation a little bit to talk about COVID, flu, and RSV. It's one of those things where we are seeing declines in these three viruses across the state regarding hospitalizations in cases, which is a positive thing to see. We did issue a provider advisory last month to health care facilities. We saw a rise in all three cases. Obviously, we're concerned about health care workers and protecting them and keeping them safe. The department through Wadsworth, our state health laboratory continues to track the variants and subvariants. Right now, JN.1 Is the dominant variant

and a little bit different than the Omicron sub variants we dealt with in 2023. I was encouraged by the most recent Morbidity Mortality Weekly Report that looked at vaccine efficacy. So far we're seeing good vaccine efficacy against what's out there. I think that's important. I'm still concerned about the relatively low vaccine uptake we're seeing here. We did send a letter with the state Office of Aging just to remind anyone who can help us with our aging population in particular that are more vulnerable just to make sure they're up to date on all three vaccines. I want to talk about another topic that we covered in our budget proposal, which is just getting to the opioid epidemic, which is a continuing public health concern for the department. It's not just fentanyl that's driving the mortality. We see the rise of xylazine more and more. A veterinary anesthetic. One of the things we put in the proposal this year was to make xylazine a schedule three so veterinarians could still prescribe it like they would any controlled substance but just making it a schedule three, so we could monitor the usage of this and hopefully prevent the diversion of xylazine which is showing up more and more. Xylazine certainly fits the definition of a controlled substance, clearly an issue drug that has the potential for abuse and dependence as we see it showing up in more and more deaths in New York. I'm going to talk a little bit about the 1115 Waiver, though, I know Amir Bassiri is going to talk more about that. I just want to extend my thanks to Amir and his team for three years of just really good work on the 1115 Waiver. Our demonstration is just, I think, another important step in New York as we continue efforts to build a health care system that benefits all New Yorkers. This demonstration bundles a series of comprehensive services to advance health equity, address health disparities, and strengthen access to primary behavioral health care across the state. There's $7.5 billion of funding over the next three years, including $6 billion in new federal funding. I'll let Amir talk more about that later. On a related note, we are waiting for our approval on the 1332 Waiver. We anticipate that getting approved soon by the federal government. Just some of the highlights not going to be increasing the income limit for essential plan eligibility from 200% to 250% of the federal poverty line. That means someone earning $37,650 could obtain this affordable coverage with no premium. This is going to affect another 100,000 Americans getting affordable coverage. In addition, we're proposing that our New York State health marketplace offer subsidies to New Yorkers within comes up to 350% of the federal poverty line who are enrolled in qualified health plans to ensure even more people have access to affordable insurance coverage. One of the other exciting proposals in our budget this year is eliminating cost sharing in both the essential plan and qualified health plans for some chronic disease. Things like office visits, lab work, pharmaceuticals and other supplies will no longer have cost sharing. It's going to affect some chronic conditions. Type two diabetes was one that I think makes sense and comes to mind. There are some others as well. There weren't a lot of investments in this year's budget. It's a challenging budget year, as the Governor's talked about time and again. I was glad to see we were able to do an investment in early intervention. We're making a rate increase, proposing a 5% rate increase across the board and 9% in some rural areas. We do have access to care problems in early intervention. Our timeliness of care numbers isn’t what they should be. I'm glad we're seeing we make this investment as well. There's an important change proposed for emergency medical services. I think a lot of people think of this an essential service right now in our state. It's not an essential service. As a result, response times can vary widely, particularly in some of our rural areas. We're hoping to change that by seeking legislation to make emergency medical services an essential service, creating five emergency medical service zones intended to augment local EMS agencies where the workforce is not quite sufficient. They're also a proposal to establish a first in the nation Paramedic Telemedicine Urgent Care Program to connect rural New Yorkers where paramedics and providers via telemedicine increasing access to care. It's example of a strategy that might reduce unnecessary emergency department visits. Just a couple more topics really quickly. I had several visits this year to

some of the tribal nations. Really, it's very important for me to get out at their invitation and visit with some of the tribal nations. There are some nice investments this year to address health disparities in some of our nations. One thing I'll just talk about is a $4.5 million investment in oral health. One of the things that I remember very distinctly was visiting the Tuscarora Nation, a very lovely people who are very hospitable to me. I really was grateful for their hospitality. That is, I was doing a tour throughout their clinic. They showed me this beautiful dental clinic. It was really state of the art, new chairs, new machine. They didn't have a dentist because they didn't have the funding to hire one. Their members were traveling a good hour, hour and a half to Rochester for dental care. I'm hoping we can do something to help in that regard as well. The last thing I'll just mention, certainly last but not least, is as a veteran myself, I was glad we were able to make an investment in our four veterans' homes. There's $22.5 million this year just to help the veterans' homes as they're recovering from the pandemic still with their enrollment. Quite frankly, admitting people. Our veteran homes can have the resources they need. I know you have a lot of briefings coming from our deputy commissioners and I do want to thank everybody for all that they're doing on our Public Health and Health Planning Council meeting. I know there's a lot of work that goes into this. Not just in this meeting, but in all the other meetings you do. I'm really happy and thankful for all the work you do. I do look forward to coming to the retreat as well. I'm glad you're doing that. I heard you were doing that. I changed my schedule so I could attend as much of it as possible.

Dr. McDonald Let me stop there and see if there's any questions anyone would have for me today.

Mr. Kraut Dr. Soto, then Dr. Kalkut.

Dr. Kalkut Dr. McDonald, thank you for your report.

Mr. Kraut Sorry, I said Dr. Soto first.

(Laughing)

Dr. Soto Nilda Soto, council member. Thank you for your report. My questions are regarding the proposed closure of SUNY Downstate and what are the plans on the impact of the patients in that area? As you probably are aware SUNY Downstate is the only hospital in Brooklyn that does kidney transplants. Where would those patients get their care? I've heard mentioned that one of the places is that people will be the inpatient outpatient be accommodated at Kings County. I wonder with the census already of Kings County how they can accommodate the additional patients from SUNY Downstate. In addition to the patients that's a big training facility. SUNY Downstate Medical School of the seventeen New York state medical schools is the most diverse. They have an additional TPT in other programs. What hospitals in the area meet the criteria to be training facilities? Are they able to bring in additional individuals for their training?

Dr. McDonald Well, I'm glad you asked. I mean, thank you for bringing this up. Obviously, it's an important issue for the area and entirely for the state too. You're right. Downstate Medical Center is a very important training facility. I did talk to Chancellor King just a couple weeks ago. He unveiled a little bit of their transformation plan to me. I'm looking forward to seeing the entire transformation plan. I think you're raising a lot of the important issues, not just access to care, not just where people are going to go. What is the whole area going to hold there? I can't get into a lot of detail about it because we are looking at what this is going to be here. I'm a regulator in this role as well, but obviously very

interested in what the outcome is. I'm really looking forward to seeing a detailed transformation plan to see how it's going to address the medical school, not just the care there as well, but all the high-level services. You gave a great example about kidney transplant services. There's a lot that Downstate does. You need to see how it's going to impact everybody down there. I'm very interested in seeing the full transformation plan. We're looking forward to hearing what their community engagement was and will be, in particular, because I think it's very important that the community be very involved in this. Thank you so much. I'm looking forward to seeing what we can do in this area.

Mr. Kraut Dr. Kalkut.

Dr. Kalkut Thank you.

Dr. Kalkut I have a question about Mount Sinai, Beth Israel and the closure plan for that institution. Can you update us to the degree that you're able to about the status of the discussions with Mount Sinai about a proposed closure of Beth Israel Hospital.

Mr. Kraut Just hold on. Your lawyer here wanted to say something.

Dr. McDonald I'd love my lawyer to say something.

Ms. Ngwashi Good morning. Marthe Ngwashi, attorney at the Department of Health. I just wanted to say for a variety of reasons, including pending litigation, we are not going to be discussing anything about Mount Sinai, Beth Israel and the proposed closure.

Mr. Kraut Dr. McDonald, I don't know if you heard that.

Dr. McDonald I heard it. Marthe did a great job saying the very same thing I was going to say.

Mr. Kraut Good cop, bad cop.

Dr. McDonald No, Martha's always, always---

Mr. Kraut I didn't say she was the bad cop.

(Laughing)

Mr. Kraut I just want to point that out.

Dr. McDonald Thank you.

Mr. Kraut If the rest of the council is not aware there was a lawsuit filed, I believe yesterday, the day before in New York County State Supreme Court by members of the community bringing it to the courts, let me just put it that way. You can read about it in today's paper for those of you were not aware of that.

Mr. Kraut Any other questions?

Dr. Soffel Good morning. First of all, I want to say that the proposal to expand continuous coverage for Medicaid for children is a wonderful step forward for the State of New York. I am delighted to see that we are taking that step. I think it's absolutely great. My question

that I bring to every time I get that opportunity has to do with staffing at the Department of Health and how we are doing in terms of trying to rebuild capacity within the department. I am hearing yesterday we had a wonderful public health committee meeting. We heard about really exciting and ambitious plans for the Office of Public Health. I am concerned about the ongoing challenges of staffing up those and other initiatives.

Dr. McDonald Thank you for acknowledging the team working on coverage for kids 0 to 6. I can tell you as a pediatrician I'm very excited about this as well. As far as staffing goes we're heading in a really good direction. One of the things I often talk about is in 2022 we really much ended the same as we started with the year. We had hired a lot of people, but we lost a lot of people. In 2023, we were positive several hundred people. One of the things I'm excited about though for this year starting in May. I really appreciate Commissioner Hochul's of the Office of Civil Service, but they're going to be expanding the hiring for emergency limited placement program. Almost all of our openings are now going to be something that we can advertise for and hire from without an exam. One of the things we're just running into, quite frankly, is our lists aren't current. I mean, this just affects the entire department. I'm optimistic by the end of calendar 2024 that our entire department is fully staffed. That's my hope for the end of 2024. By the way, I do want to thank Commissioner Andy Ruby, who's done a great job as one of our deputy commissioners administrations. His team has done a great job. We are hiring a lot of people. I think one of the things that I'm really seeing with a lot of the young people we're hiring in particular is people recognize the Department of Health is a positive place to work with a really powerful mission. People are signing up for that. I'm seeing nice enrollments in area. I mean, one of the things we're seeing, we're hiring more nurse surveyors. Of course, they take six to nine months to train, but I'm seeing nice increases in that area, which I'm really happy about too. It reduces our vulnerability when it comes to regulating our license. We're making progress here. I'm really excited about what, civil service is doing. Very, very excited about what can happen in May. Thank you.

Mr. La Rue Good morning. Scott La Rue, a member of the council. First, I wanted to share my enthusiasm with you for the interstate pacts and licensure and as well as the proposal around the MedTech. As you know, the staffing in nursing homes is a very challenging environment. If the average nursing home resident has eight medications at least half of them is over the counter. You do not need an RN to dispense those. It's not allowing the RNs to operate at the highest level of their licenses. It's creating a career ladder for the CNAs to become MedTech. I really am enthusiastic about your proposal in the budget. I hope the legislature, participates in that enthusiasm. Secondly, I just wanted to mention about the staffing regulations and the 3.5 that the legislature passed. I think it was April of 2022. That still has not been funded. I really encourage the executive branch and the department to work with the legislative staff to fund that really necessary mandate but at this point in time it's severely underfunded. I would really encourage some reconsideration on that point. Thank you.

Dr. McDonald Thank you for your feedback. I appreciate it, Mr. La Rue.

Mr. Kraut Any other questions?

Mr. Kraut Well, Commissioner, again, thank you for joining us. Thank you again for agreeing to participate in the retreat. We'll be in coordination with your office as we shape that agenda and appreciate your report. Thank you very much.

Dr. McDonald Thank you so much, everybody.

Mr. Kraut Thank you.

Mr. Kraut There were two things I neglected to do, one during the annual meeting. We have in front of you on your desk a 2025 listing of dates for both our committee meetings and full council meetings and their locations. We need to approve those dates. We make the reservations for the use of facilities in those locations.

Mr. Kraut If I could have a motion to accept the 2025 proposed dates.

Mr. Kraut Mr. Thomas.

Mr. Kraut Second, Dr. Watkins.

Mr. Kraut All those in favor?

All Aye.

Mr. Kraut Opposed?

Mr. Kraut The motion carries.

Mr. Kraut Lastly, I failed to mention that at the end of the meeting we are going to go into an executive session to consider a health personnel matter. Please don't depart before we're able to consider that matter before us.

Mr. Kraut I'm now going to ask Mr. Herbst to give us a report on the activities of the Office of Aging and Long-Term Care.

Mr. Herbst Thank you.

Mr. Kraut Thank you for joining us.

Mr. Herbst Thank you, Mr. Chairman.

Mr. Herbst Good morning, council members. You have to bear with me. I went to the Rangers game the other night. I was very enthusiastic. Went into overtime. I'm blaming the Rangers for me losing my voice. Not for any another reason. Please bear with me while I'm still a little hoarse here. They did win. The Rangers won.

(Laughing)

Mr. Herbst Good morning. I'd like to give some updates today on the wonderful work that the Office of Aging and Long-Term Care has been doing for many months now. Towards the end of my comments, an update on what we're doing at the state on our master's Plan for Aging. Let me start with something that I've discussed a handful of times. I want to give a particular update because we have some news with respect to the program for all-inclusive care for the elderly better known as PACE. When we discussed this at the November meeting the Governor signed into law Article 29EE, which creates an entirely new licensure category for the Certificate of Need review for the PACE program. This program offers a coordinated model of care which features an interdisciplinary team of health care professionals. It provides a comprehensive benefit package that's designed to

empower members to maintain their residence in the community rather than other types of settings like a nursing home, for example. The program encompasses the operation of a PACE center, where members of the PACE program receive a variety of services, including medical care, socialization opportunities, and other PACE services, and adopts capping financing and facilitates the delivery of all-encompassing services that are tailored to the participant's specific needs, which surpasses the limitations imposed by conventional Medicare or Medicaid fee for service plans. What I'd like to update now is that work is being done by the Office of Aging and Long-Term Care in coordination with the Medicaid Office to implement provisions of this law and finalize the regulation, development and the unified application and CON scheduling. We're very excited that applications continue to come in. We're hopeful that over the next several weeks we will have approval to hire additional staff within the Office of Aging and Long-Term Care to help with this new model of unit which will work exclusively on developing the protocols and the review materials for various care models, such as PACE and allow us to carry out the provisions of this law. Until that time, the Article 29EE based licensure process is fully operational. Applicants are now encouraged to apply under the existing process, which includes using Articles 28, 36 and 44. Once the new article 29EE application program becomes operational those applications will be submitted under the existing process will be transitioned to the new Article 29EE review process. We're very excited about this and will bring, I hope, at the next PHHPC cycle some additional ideas with respect to the changes and anticipate the final regulations for the Spring. I also do want to note that CMS must still provide final approval of PACE programs. This law only changes the method that the state conducts its review of the new establishment applications and not the program itself. Next, I'd like to talk about something we're very excited about, which is hospice and palliative care. In the Office of Aging and Long-Term Care we launched the new center for Hospice and Palliative Care, which remains a top priority for us. And the Governor, highlighted in our commitment and the Governor's State of the State. This commitment addresses disparities and access barriers to end of life care. This new center will be led by a director, which is now being posted, if anyone knows good candidates. We'll have active recruitment of about six new roles that will support that director. We're very excited about this new center, which will partner with internal and external stakeholders to assess policies and hospice resource utilization in New York State and across the country. We look forward to educating the public on hospice and palliative care, develop and communicate models, new models of practice, and build strong cross continuum stakeholder relationships. The center will be tasked with examining the underlying reasons for low hospice utilization in New York State. As part of our commitment, we look to develop a public education plan that addresses the trends and increase equity and accessibility of hospice care opportunities in New York State. We also plan to examine palliative care models that concentrate on the early stages of the disease so that we can share model practices that will reduce unnecessary hospitalizations and result in better patient outcomes. Next, I'd like to discuss a few long-term care specific budget highlights that were in this year's executive budget. The executive budget proposes actions that address a stressed workforce, as the Commissioner mentioned, by expanding and providing flexibility and scope of practice that would allow, as Mr. La Rue pointed out, for certified medication aides with the appropriate experience, training and competency to administer certain medications in nursing homes. The executive budget also sets forth a comprehensive plan of amendments for the Public Health Law that expands access to care in the home through the Hospital at Home Program, which would authorize inpatient care at home and would enable the state to develop a Medicaid rate to support this innovative model of care. This expansion would be accompanied by changes to the Public Health Law 2805 that will encourage additional collaborations and service delivery. It's our goal that the programs and initiatives such as these will address service gaps and

community health care needs by expanding these types of providers who are transforming and expanding the way the care is delivered. In addition, the executive budget is seeking to improve the quality and transparency of assisted living residences by establishing quality reporting metrics and accreditation. We look forward to further discussion with the PHHPC and with our industry partners on this important initiative. Finally, another strong and important long term care proposal in the executive budget would support families and informal caregivers of individuals with various forms of dementia by strengthening the Special Needs Assisted Living Residents Voucher Program, better known as SNALR by clarifying that the voucher must be used to subsidize SNALR costs and promulgating regulations that govern this program. We will enable consumers to make informed decisions regarding the care their loved ones, while ensuring funding remains available to support the care that they need. Given the history of the waiting list and the growing interest in the SNALR voucher program, we strongly look forward to supporting this proposal. Next, just very briefly, I'd like to just give some highlights of the OALTC, the Office of Aging Long-Term Care Nursing Home Quality and Support, which has been tremendously busy. First, the team has been working to support financially distressed nursing homes. We've been working to hold our partners to ensure that they provide the right type of documentation if they want to receive the funding through the state, both, including a $50 million grant for funding allocated through alternative models of traditional nursing home care. The statewide four RFA was released on January 9th. I want to remind people that regarding the RFA for this, it is due February 14th, just next week. Responses will be posted publicly on or around early March. We anticipate awards to be announced in this Fall. The primary purpose of an additional funding is the VAPAP program, a vital access provider program to provide short term financial assistance to distressed nursing homes while they are thoughtfully planning for the future of their facility. The department continues to accept applications of the VAPAP applications on a rolling basis. Since the program's inception, we have been awarding many nursing homes VAPAP funding to ensure they are providing the short-term financial need. Finally, the Master Plan for Aging, an important initiative that the Governor signed into law in December 2022. We have been very busy developing a transformative and sustainable set of recommendations that will go into the state's first Master Plan for Aging. We look forward to providing this final master plan later this year. What we've been doing is going around the state to different communities, different churches, synagogues and mosques, different aging communities, schools, different networks and having town halls and listening sessions so we can hear from various communities, every community, for that matter, what their interests are in participating with respect to the Master Plan for Aging. We also have a statewide survey that's been tremendously informative. I encourage everyone on this council and everyone listening today to fill out that survey, which is on the Master Plan for Aging website. We have printed copies if you'd like to get those as well. We have been learning so much about this master plan of what the state really is desiring. It transforms beyond just health care. There are so many other areas of public health prevention agenda. Thank you, Dr. Boufford, for your participation and partnership. There is housing. There is transportation. There is technology. There are so many different areas that we are including into our Master Plan for Aging to help our aging. All of us are aging. Our aging community and our disability communities. We're very excited about providing updates to this council and other councils over the course of the year as we finalize our final Master Plan for Aging report. One thing I do want to highlight is that although the report is going to be due this year it's not like we're simply handing a document in and then saying we're done. Rather, this is just the beginning. This report once it's handed to the Governor and distributed to the public will enable us to look forward ten years out. We have developed a special unit within the Department of Health and our partners in State Office of Aging and other state agencies to ensure that the program and the services and all of the ideas that are being

put together in this master plan will be sustainable, will be carried out and ensure they are a live document for many years to come. We anticipate much work to be done not just this year, but over the next ten years as a result of our final report. We're very excited, enthusiastic with all of your participation to see that this plan is successful and fruitful for many years to come for all of us as we age in the state of New York. Thank you very much.

Mr. Kraut Thanks so much, Mr. Herbst.

Mr. Kraut Questions?

Mr. Kraut That was a really good report.

Mr. Kraut Yes, Mr. La Rue.

Mr. La Rue Good morning. In your written report, you mentioned the alternative model of care unit. Could you expand on that a little bit, please?

Mr. Herbst Sure.

Mr. Herbst Under Mark Furnish to my rights lead, we have created this new unit that will help us with our PACE programs, with our hospice programs, and all of our licensure matters. This unit will be dedicated exclusively to ensuring that PACE applications, for example, get carried through and are not sidetracked with other work that Mark's team is working on. We have created a dedicated staff to focus exclusively on the work that I highlighted in this report.

Mr. Kraut Ms. Monroe.

Ms. Monroe Thank you, Adam.

Ms. Monroe Yesterday I read that the federal government might be rescinding its approval of hospital at home because of lack of use and lack of accountability, all kinds of reasons. Have you heard that? What might we do in New York if, in fact, that actually comes to pass?

Mr. Herbst Thank you, Ms. Monroe.

Mr. Herbst I have not heard that, actually. I do anticipate that no matter what happens at the federal government we in the state of New York are looking forward to transforming the way care is delivered, which is outside the walls of the hospital. We think that there is quite a bit of interest and need from our state partners, in the hospital systems and the patients to see that this is scaled up. We will continue to make sure that the Hospital Health Program is successful, irrespective of what the federal government is going to do. We are working with Amir's team, like I mentioned, to ensure that there is some type of rate there from the Medicaid program. We are working on all cylinders to make sure that this program is scaled.

Ms. Monroe Thank you.

Mr. Herbst Thank you.

Mr. Kraut Thank you so much.

Mr. Kraut Now going to call on Mr. Bassiri to give a report on the Office of Health Insurance Programs.

Mr. Bassiri Thank you, Jeff, and nice to be with you this morning.

Mr. Bassiri My name is Amir Bassiri. I am the Medicaid Director at the Office of Health Insurance Programs at DOH. I want to give an update specifically on our recent approval for the 1115 Waiver amendment, which occurred January 9th of this year. As Commissioner McDonald said, it has been a long process, taking a village to get to where we are. We were negotiating with the Center for Medicare and Medicaid Services for about fifteen months on this amendment. Ultimately, we landed, with a $7.5 billion waiver approval over the next three years with about 80% of the waiver being federally funded. It is in concert with other waiver amendments that CMS has approved nationally. This is the largest they've approved. This is the most federal funding they've provided. We do have less time, traditionally. I'll talk a little bit about that and how we're mitigating against that. We're very, very excited to finally be here. The goal of this amendment is to fundamentally change the way we pay for and deliver Medicaid benefits and integrate social care services, along with our physical and behavioral services to address some of the health disparities and inequities throughout the state. By way of background, the 1115 Waiver, I know many of you are familiar with it. New York has a unique structure. We've had most of our managed care program authorized under this 1115 Waiver since 1997. The last big demonstration you're all familiar with. This is not a demonstration. It's an amendment. We have our current demonstration and process. It is between March 31st of 2022 to March 31st of 2027. We're amending that 1115 to incorporate several new authorities and flexibilities, but primarily health related social needs services that we are integrating into the managed care benefit package. We've added a goal to our amendment specifically around health equity. We view this as from the Medicaid programs perspective our strategic plan to address health equity. We don't intend for it to be time limited. This is something we intend to be a permanent fixture and how we do business and some of the delivery system reforms. There are three main pillars of the waiver. It is dense and wide. There are three main major pillars starting with development of social care networks and integration of health-related social means. That is about $4 billion of this seven and a half. It's the core focus. It's the research question that both New York and other states and the federal government are evaluating and hoping to evaluate thoroughly to assess whether inclusion of these benefits and funding from Medicaid will improve overall population health and reduce or be equivalent to current spending on medical services. It's a very ambitious goal, and one that we are going to have to work in rapid fashion to actually measure within the next three years. We have done extensive planning and preparation. We do have some things that are currently publicly available like our request for application to award these new social care networks currently in the application process. I'll talk a little bit about that. The social care networks are the core focus. One of the newer entities that we intend to establish in the Medicaid delivery system. They build upon a lot of the things that we have done. However, there's an evolution that has taken place. These are intended to be contracting entities taking on fiscal responsibility, coordination of benefits and services and HIT and HIE related functions to support community-based organizations and other health care providers for geographic regions throughout the state and serve as the basis for bringing community-based organizations into both the patient flow and the reimbursement model of the Medicaid program. These social care networks. We are planning to have one per region with New York City heading up to five. We will see what comes in. We are very much encouraging partnerships given the scope of

responsibility of these organizations. There is some of the work happening throughout the state. It would not be statewide. Organizations are going to have to come together to be able to stand up the infrastructure quickly and support their CBO and other health care partners. We intend for that to happen by August is our goal to have everything set up and funding to flow to these entities. Everything will begin in terms of their service delivery through a standardized, uniform screening and referral tool. That tool is very, very important to some of the things Jim spoke about earlier and our ability to evaluate outcomes and benefits of these services. There is going to be every Medicaid member, regardless of managed care or fee for service will have and go through a social care screening assessment. That assessment will flow through these networks. They will go to the State Health Information Network, health plans. They will trigger and identify what services an individual would benefit from or be eligible for. Everyone, regardless of what that assessment says will have access to what we're defining as level one case management services, which would be some linkages to existing state and federal programming, benefits and services, certain populations, more vulnerable populations, those that are in the health home eligibility criteria, pregnant persons and children, those being discharged from incarceration will be eligible for higher level or level two health related social needs services. That includes nutritional services, groceries, pantry stocking, home delivered meals, cooking classes, things of that nature, as well as transitional housing, supportive services, tenancy supports even rent and board for a temporary period of time, medical respite services and other linkage and care coordination services to get people into stable housing or transitional housing while we place them in permanent supportive housing. We're very, very excited about that. There's a whole suite of services. We're planning to do a very detailed webinar next week where you can see a lot of this information. There are some details in our current RFA for the social care network. You can see the data infrastructure and how we've thought about building this new entity and why we believe we've done it in a way that is intentionally done so that these entities are permanent fixtures and how we do business in Medicaid. There are some other health related social needs services that are new, including transportation. Medicaid normally pays for either emergency or non-emergency transportation, limited to access to medical appointments. This would be new transportation services to connect to social benefits and social care providers, which is a new service that would be included in this package. That is the core focus and primary funding of the waiver and one of the first pillars. There are some other very large initiatives under two pillars. I'll start first with population health improvement and health equity. We were able to secure funding for a statewide health equity regional organization. This will not be a government entity. It will be an independent entity that will be responsible for doing some of the regional planning and engagement of stakeholders to identify region specific health equity priorities and needs. They will also be working to support data aggregation of this new social care data with some of our other health medical data in the Medicaid data warehouse, as well as census data and other data sources to really enrich the information that we have on our members, who they are, what they need, if they're getting what they need, and what the outcomes of those referrals and services are. Will also be supporting and developing new value-based payment arrangements that could be funded and included in some of our managed care funding after the waiver depending on what type of innovation works and what stakeholders are saying is addressing some of the health equity priorities of any particular region, whether it's maternal health or behavioral health. They will do a lot of planning activities in that regard. There's also a very large primary care focus of this waiver. We work very closely with CMS, as well as the center for Medicare and Medicaid Innovation. Their primary care models that have recently been announced. We're trying to align where appropriate and also just catch up because as the State of New York as well as many other states have fallen behind in terms of the percentage of primary care in the health care dollars. We

have a very robust infrastructure through DSRIP and the PCMH program. We see very good outcomes in the PCMH program. The federal government is interested in aligning Medicare primary care transformation in accordance with what Medicaid has done. PCMH is going to be that link both for upcoming and new Medicare investments as well as statewide Medicaid investments that we have in this year's budget and which would roll out starting next year with an enhanced PMPM for both adults and children differential enhancement to really focus on increasing our investment in primary care and streamlining some of the quality improvement activities to align with what Medicare is doing in some of their new models. There is also a large policy change and unique demonstration Downstate that is outlined in the waiver. It is tied to the funding we were able to secure for financially distressed hospitals in the Downstate region. It is up to $2.2 billion. It serves as a bridge in many ways towards a new way of financing hospitals under a global budget demonstration. That is also in relation to a Medicare demonstration that would start in 2027. It is a voluntary model. Other hospitals can and we encourage them to participate if the state applies later this Summer. The funding is specifically for distressed hospitals is to stabilize and help prepare for the rebalancing of care from inpatient settings to ambulatory care settings in partnership with primary care providers and other community-based providers with total cost of care, accountability and population health outcomes that we hope to improve upon. The last component is workforce. This is very unique that we were able to secure workforce funding in this. There is no other 1115 Waiver approved in this cycle that has funding for workforce in this way. There are two primary workforce programs starting with that career advancement pathways training programs, which will be also leveraging existing infrastructure created under DSRIP through our workforce investment organizations, which had initially been established with a long-term care focus. We are really targeting to work with more sophisticated and more comprehensive that have expanded beyond only supporting long term care workforce and that have the capability and relationships, partnerships with educational institutions and employers to do healthcare training for nursing titles, for mental health practitioners, and new social care providers like community health workers and peer support navigators to support that social care infrastructure that we're building through the waiver. We hope to train or retrain at least 18,000 positions across various titles. It is going to be very challenging, but we are very excited about the opportunity and have been working closely with some to identify best practices and their capability. The other component that is much different than a training program is a small piece of loan forgiveness that is being targeted in a very specific way to titles for which we have a dearth of availability in the Medicaid program and widespread access issues such as psychiatrist, dentist, pediatric nurse specialist, primary care physicians. We are going to have some opportunities for loan forgiveness under the condition that anyone who receives loan forgiveness would commit to a service area requirement that they work at a Medicaid enrolled provider that serves at least 40% Medicaid and uninsured for at least four years. There is a large commitment. The loan forgiveness amounts are pretty significant with up to $300,000 for a psychiatrist. There are some additional initiatives. I think I heard Ann mention one that I'll just touch on. It's not specifically in this waiver. It's tied to the agreement, which is continuous eligibility. Medicaid and child health plus up to the age of 6. We have a pending amendment right now. We have some upcoming public forums. I'm happy to get information to the council. We'd love you to attend and encourage comments, but I've been talking for a while now. I need a sip of water. I'm sure you have many questions. I'm happy to pause.

Mr. Kraut Well, thank you very much. Congratulations on getting it to this point on the field and little over the goal line. As you know, we've been asking for this kind of presentation for a little while. Until the documents became public, it was difficult to have this conversation. That's why I'm giving them all the time they need to kind of go through these.

I think this is something we're going to be hearing about and talking through. Our role is somewhat limited. You're starting to see the framework of how health policy alignment is going where they're making the money and the investment and everything else kind of has to change behind that in order for this to be successful.

Mr. Kraut I'll open it up for questions.

Mr. Kraut Doctor Ortiz.

Mr. Ortiz Just more of a comment. It was great to hear you talk about workforce as Dean of a School of Nursing. In looking at the ability to create tracks for future nurses to progress from CNA to LPN to RN into advanced practice. I just hope that your office has the ability to work with State Ed and Office of Professions in a very seamless and transparent manner. There are many challenges to the regulations. There are three nurse associates in the Office of Professions who each interpret all the regulations differently. As past President of the State Council of Nursing Deans, I heard many, many frustrations and many emails from nursing deans trying to do unique and creative programs that would streamline and shorten the pathway. The regulations seem to stand in that way. Anything you can do, we be happy to help, of course. I just wanted to put that comment out there.

Mr. Bassiri Thank you for the comment. I think as you heard Commissioner McDonald earlier, it's something we're very focused on. We have engaged SCD. We are not necessarily asking them for any special flexibility with respect to these training programs. It is something we're very focused on more broadly.

Dr. Boufford Amir, congratulations on really hard work and continuing to focus on population health. I have two questions. One, is really about the social care network development. One of the learnings, I think, in DSRIP and other areas is A, that many nonprofits who are providing social services, the kind of supports that you want for complex patients do not have the capacity to scale up their ability to deliver services. That's one part. The second part is the degree to which developing networks takes time. I mean, there's a good example in Brooklyn. There's been sort of three, four or five years now with a very robust network of community health centers involved there. I think the time frame you're talking about of hitting the ground in August really raises two questions. One is, is there a potential for investment in administrative fiscal as well as staffing capacity in nonprofits as part of the funding ask that people would make not just bringing people on or beginning to sort of have a target number? The second question was just, what's the role of health plans in all this? It seems to me, ironically, they of all entities would have the greatest interest in integrating health and social care and managing patient costs. They seem to be kind of an afterthought. Those are my two questions. Thanks.

Mr. Bassiri Great questions.

Mr. Kraut We have a second by Dr. Bennett.

Mr. Bassiri You reminded me. I glossed over the health plan’s role. It's not insignificant. It's certainly not an afterthought. This is actually a lesson learned from the DSRIP waiver, where I think we acknowledge that not having health plans is integral to the delivery is why we haven't seen some of the lasting impacts of the policy reforms once the incentive funding is gone. We actually have put health plans very much front and center. They will have a very large role in supporting the networks, in ensuring that we can adequately measure and evaluate how these screenings and referrals, what the result is, whether

people are improving or reducing health care utilization as a result of receiving these services. They are going to be very involved start to center with all aspects of the 1115 Waiver with the exception of, I think the workforce investment organizations, although we do have some reporting that we use to do with the health plan. They are certainly front and center. They will have a very large role. Some of the health plans have actually done a lot of this work from the screening and assessment standpoint. I'm sure Dr. Bennett will mention what --- done. We are really taking what we've built and what we've learned from what's happening to try and just scale statewide and fill gaps because health plans can't do it alone. The networks can't do it alone. Together, we think we can fill some of the gaps and target health equity improvement for some of our more vulnerable members.

Mr. Kraut Dr. Bennett.

Mr. Bassiri I had mentioned there's $4 billion for both the infrastructure for the networks and the services. $500 million is for the infrastructure, capacity building, training, CBOs support, organizing, outreach are all eligible funding streams within that $500 million. We know this is going to take a lot of work. It will take a lot of partnerships. There are parts of this state that are further along and have really built on what the successes of DSRIP were to take it further. I would say different regions are at different places. We're working as quickly as possible. We want to leverage the federal funding as quickly as we can. We know that people have been preparing and planning and expecting this to happen. Some of that work has started.

Dr. Bennett Thank you for those comments. We're pleased to see it. As you said, if we want to get long term benefit from this investment you need to have this centered around the health plans. The one thing that concerns me, and I don't know whether it'll be an issue or not, is that because we basically were excluded from really the first DSRIP program there wasn't really much in the way of increased costs of administration. I'm always worried about unintended, unfunded mandates because that'll put a further strain as you very rightly said, we're doing a lot of this. We already have links with most of the community benefit organizations in the Capital Region. Our people are in there where they have EMRs we're connecting to them. We've already made a lot of these investments. We're not unique. Well, maybe we are. We like to think we are. Others have done similar things. I just would hope that as this rolls out that the department be conscious of not giving us an unfunded mandate where there's we have to do something new that we can't really afford.

Mr. Bassiri Thanks for the question, Dr. Bennett. Very much top of mind. This will not be an unfunded mandate. I will tell you that the rates will be actuarially sound. I assure you that. We are also planning to use vehicles like state directed payments and other things of that nature that have administrative funding components to them. We know this is not easy work. For a plan like yours I think it's well positioned to be very effective quickly and get reimbursed for things. You're probably not reimbursed for today.

Dr. Bennett Thank you.

Mr. Kraut Dr. Torres.

Dr. Torres I wanted to pause earlier in making a comment only because I was waiting to hear your presentation. It was an honor and exciting to host the MPA meeting in one of the community sites. Interestingly enough, there were also other groups and individuals that wanted to also comment on the waiver and use the MPA forum to do so as they saw an

impact on the aging, community as well. I just wanted to make that point. Thank you for the clarification and more discussions coming in the future.

Mr. Kraut I'll give the final question to Dr. Kalkut.

Dr. Kalkut Thank you. Congratulations, Amir. I'm Gary Kalkut from the council. Could you comment briefly, if you can, on data infrastructure to track screenings and referrals health related social need referrals? The data during DSRIP was a keystone to improve.

Mr. Bassiri This is the thing I'm the most excited about. What we put the most, I think time planning and effort into is the social care data infrastructure and its change, both, at the provider level as well as the statewide level. There's a lot of this in the social care request for application that is publicly available in terms of the visuals. You can understand and see the architecture in a much clearer way. The assessments will be done primarily by community-based organizations and or health care providers that have the capability to do them. They'll flow through the social care networks. We have focused very much so...I know not everybody loves this, but on standardizing that information. It is not going to be perfect because we know that this is a nascent market. A lot of people think they know and have the best screening tool to assess a member's social care needs. Ultimately, if we don't have uniform and standardized data we will never be able to evaluate what works and what doesn't. We would have that standard. That is where everything starts. It flows through the social care networks. It will be housed in a data lake and connected to the SHIN-NY. We will have access to integrating that data with other Medicaid data in the warehouse. Through our partners, both in the SHIN-NY and the state, we would be able to integrate that data and release it to the regions or more publicly in a way that we can monitor and evaluate what's working in which regions, where and when. I'm summarizing it pretty rudimentary. There is a lot behind it. There is no other state, even the other 1115 Waivers who are doing this type of work. They haven't built infrastructure on the data exchange like we have. They don't have the benefits of a statewide HIE like we have. We are really trying to leverage the infrastructure that exists such that this can continue in perpetuity and in a way that it will continuously improve and help us evaluate whether it's working and whether it's cost effective.

Mr. Kraut I made a mistake. I gave Dr. Kalkut the last question on the left side of the room. I'm going to give on the right side of the room to Ms. Monroe.

Ms. Monroe I'll make this quick.

Ms. Monroe Thank you for that explanation. One of the things I think we learned in DSRIP is to follow the money. I'd like to just ask you a dollar comes into you and down at the other end of this whole transaction is a person who needs a ride. How does that dollar flow down to that person?

Mr. Bassiri It's a great question. We'll actually go through this fund flow, Ms. Monroe, in a public webinar next week. We are going to establish a per member per month premium for the social care services. That's going to be challenging in the first year because there is no historical information to base that premium on.

Ms. Monroe Does that go to the health plan or to the social care network?

Mr. Bassiri It goes to the health plan, and it is directed to the social care network through a state directed payment, meaning we will be able to follow it from health plan to social

care network. The social care network is responsible for a lot. One of which is establishing a fee schedule for these different services with the CBOs. It would be a fee for service like fee schedule for services. The service you described would be on that fee schedule. They would coordinate the referral to that provider based on that member's screening and assessment form. If the referral was paid, the service was provided, the provider would be paid for that transportation.

Ms. Monroe By whom?

Mr. Bassiri By the social care.

Ms. Monroe Okay.

Mr. Bassiri The social care network will be paying their network of community based and other health care providers directly.

Mr. Kraut I would just tell you, as we move from what's written on paper to reality, I'm sure a lot of the questions will get answered. As Mr. Bassiri said, the webinars that are scheduled, I would encourage everybody to watch them. Colleen, I'll ask you to send those links out to the board members. Thank you very much.

Mr. Kraut Now, I'd like to introduce Dr. Bauer to give a report on the activities of the Office of Public Health.

Dr. Bauer Thank you so much.

Dr. Bauer Good morning, council members. The Office of Public Health is looking forward this year to finalizing the framework for the next cycle of the prevention agenda the state's Health Improvement Plan. When we launched the new prevention agenda framework in 2025 hospitals and local health departments, along with their community partners will be using that new framework to plan their work over the six years of the cycle. Yesterday at the meeting of PHHPC's Public Health Committee OPH presented two potential frameworks, one of which is a direct descendant of the current plan, mirroring the existing priorities and focus areas, and one that takes an updated approach to advancing public health by more formally recognizing and integrating into our strategies the known relationships between the vital conditions or the social determinants of health that we all need to thrive. Those are the things we've just heard about in terms of the 1115 waiver, stable housing, transportation, good nutrition and include things like safe, natural spaces, quality education, living wage and so forth. All of those, as we know, through our work with social determinants of health are an even greater force for health than even health care. While health departments and hospitals are not responsible for addressing conditions like poverty and low high school graduation rates and so forth we've long recognized those conditions as the root causes for poor public health. The updated framework, which was under discussion with the Public Health Committee yesterday takes the recognition of that relationship a step further and empowers and exhorts hospitals and health departments to actively partner, to invest in communities and help address these health-related social needs. There were questions yesterday from the Public Health Committee about how hospitals and health care organizations can do that. We have just heard how the health care delivery system can transform, can partner with the community, can work with community organizations to really change the trajectory for patients and for community

members. It's really exciting to hear now about the 1115 waiver and how that will be moving forward and potentially how the prevention agenda can align with and support that work. I'll refer council members to our OPH written report for our office of Public Health updates. I will call your attention, though, to the success of our WIC chat bot known as Wanda, who has been providing information and referring New Yorkers to the WIC program. This year just launched, last month Wanda now offers all of that guidance information and referral in Spanish. We're looking forward to expanding our reach for the WIC program. I'll also note included in the report the Center for Environmental Health has several regulatory updates underway, including modernizing the regulations related to ionizing radiation and revising the state's food code, which, of course, we're doing in sync with the Department of Agriculture and Markets with the goal of better aligning with the federal government's model Food Code. Those are a handful of updates from the Office of Public Health. Thanks very much.

Mr. Kraut Great.

Mr. Kraut Thank you.

Mr. Kraut I have a question. It's not a question. It's just a recollection. I believe the prevention agenda has to get approved by the council in order to be adopted. At some point in the future, as it comes through the Public Health Committee it will get presented here at one of our meetings for adoption. My recollection is we have to do that in order to recertify for the state and stuff like that. I know we're going to hear from Dr. Boufford as well.

Mr. Kraut Do you have comments for Dr. Bauer? Any comments? Questions?

Mr. Kraut Thank you. Thank you so much.

Mr. Kraut I'll now turn to Dr. Fish to give a report on the Office of Primary Care and Health Systems Management.

Dr. Fish Thank you.

Dr. Fish Good morning, council members and guests. It's a real privilege to be with you here today in this role. Thank you, Mr. Kraut, for the kind introduction earlier today. Just a friendly amendment. I'm acting in the acting capacity Acting Deputy Commissioner role of the Primary Care and Health Systems.

Mr. Kraut You think you're acting.

(Laughing)

Dr. Fish I'm learning a lot. I've spent my last nine years, as you mentioned in the Office of Health Insurance Programs working with them here in the Medicaid program. That's been a real privilege. Just a couple of comments. Just two topics that I'll touch on today in the interest of time. One is, the Certificate of Need Program. Governor Hochul announced in her State of the State Address that to alleviate strain on both providers in the state she'll instruct the department to make necessary updates to the state's Certificate of Need Program, such as raising financial thresholds that qualify a project for more detailed review and streamlining the application and approval processes, including for what are now routine services. Project cost thresholds were last raised in 2017, and construction costs

have escalated as we all know. Updating the Certificate of Need process will help to ensure that it continues to advance its objectives as responsive to a changing health care environment focuses the department and the Public Health and Health Planning Council resources on issues and projects of greatest impact and is a streamlined and expeditious as possible within the parameters of the statutory authority. The second topic is just an update on the statewide health care transformation program. A total of $1.6 billion is authorized through fiscal year 2024 for statewide health care transformation programs and our statewide efforts. $650 million of the statewide four appropriation has already been awarded, including $450 million for statewide three projects and $200 million for emergency room modernizations. $950 million remain to be awarded under three requests for applications just announced under the statewide four and five programs as follows: first $650 million for health information technology, cybersecurity, and telehealth transformation projects through statewide four and five funds through our Office of Quality and Patient Safety. That was released on January 2nd with applications due March 13th of this year. Second, $50 million for residential and community-based alternatives to traditional nursing home care through statewide four funds released a January 9th with applications due April 9th. $250 million for facilities to drive transformative healthcare investments with priority given to facilities in severe financial distress using statewide four funds. This was released also on January 9th with applications due March 26th. Separate from these statewide RFAs the council should also note that a new Health Care Safety Net Transformation Program for hospitals is proposed in the fiscal year 2025 executive budget under Health and Mental Hygiene Part S. The Executive Budget Bill language authorizes and directs the State Comptroller to transfer up to $500 million of funds from statewide four and five to fund this program. The goal is to improve access, equity, quality and outcomes while increasing the financial sustainability of our safety net hospitals. With that, I'll just wrap up and see if there are any comments or questions.

Mr. Kraut Any questions for Dr. Fish?

Dr. Soffel I have one very quick question. I'm sorry, Jeff.

Mr. Kraut No, it's okay.

Dr. Soffel I'm just a little bit confused about the dollar flows here because as I'm reading the report and what you just said is that there's still $950 million remaining under four and five and it's been allocated in three different buckets, but then somehow $500 million more is going to go to this new health care safety net transformation program?

Dr. Fish That's correct. An additional $500 that's proposed in the budget this year.

Dr. Soffel So this is new money?

Dr. Fish This would be new dollars, yes.

Dr. Soffel It's not being transferred from four and five?

Dr. Fish No, it's, not part of the original $1.6 billion. That's correct. It's separate.

Dr. Rugge Actually, I think that it's not new money. I think it's actually money that had been previously not spent. It's being reappropriated from other unspent funds into that particular bucket that he would not know that because it was before his time.

Dr. Fish Thank you.

Mr. Kraut Every time you issue an RFP it's new money as far as people are concerned.

(Laughing)

Mr. Kraut As long as you get to spend it.

Dr. Fish Thank you.

Mr. Kraut Thank you so much.

Mr. Kraut I'm now going to ask Miss Kim to give a report on the activities of the Office of Health Equity and Human Rights Management.

Mr. Kraut Ms. Kim.

Ms. Kim Thank you.

Ms. Kim Good morning, almost most good afternoon to the council. I'm delighted to provide you with updates on progress to date with work that is happening in the Office of Health Equity and Human Rights. My name is Tina Kim. I'm the Acting Deputy Commissioner for the Office of Health Equity and Human Rights. First, I wanted to highlight a few programmatic updates from the AIDS Institute. The Department of Health is preparing for amendments to the Public Health Law to go into effect May 3rd, which will require a syphilis test during the third trimester of pregnancy, in addition to testing at the time of the first examination. The AIDS Institute is creating a frequently asked questions document and communicating with providers on needs to support the implementation of syphilis screening during pregnancy in the third trimester. The frequently asked questions will include information about existing and new requirements for the screening to ensure that there's a single comprehensive document for New York State providers. We will continue to monitor and work with providers as this law goes into effect later in May. The AIDS Institute is also continuing its efforts to address the harmful impact of crystal methamphetamine use. The AIDS Institute has directed multiyear funding to Trillium Health and Evergreen Health to address crystal meth use in the Western New York Region. This funding complements the great efforts of partners at the New York City Department of Health and Mental Hygiene that they offer through the five New York City boroughs. The University of Rochester also received one year funding to conduct a pilot research study to learn about the current impact of crystal methamphetamine use, specifically among Black men who have sex with men across New York State. The AIDS Institute convened and successfully conducted two community virtual discussions, which held space for education and awareness to talk about the impact of crystal methamphetamine use in communities, and in particularly communities that often experience societal political marginalization. We will be continuing those efforts through the course of 2024. I do have an update that we were not able to include in our written report, but I'm happy to share verbally. This is an update from the Office of Diversity, Equity and Inclusion. The Office of Diversity, Equity and Inclusion within the Office of Health Equity and Human Rights will be conducting a training for DOH staff this Tuesday. This is for staff that are overseeing boards and councils within the Department of Health. As you all may know, the department oversees a convening of over forty advisory boards and councils. The objective of the ODEI training, titled Enhancing DOH Councils and Boards Through Diversity and Inclusion is to provide DOH board and council liaisons and

affiliates with knowledge and understanding of diversity and inclusion updates related to vetting processes, defining diversity and inclusion and its alignment to DOH boards and council, reviewing and education on current and innovative practices, support and resources for board and council education, outreach and improvement, and identifying next steps towards working with each DOH council and board and the staff to oversee them. The Director of the Office of Diversity, Equity and Inclusion continues to serve as a DNI liaison, responsible for now reviewing all incoming DOH council and board candidates. This is towards the goal of increasing diversity within the boards of counsel that are responsible for making key decisions impacting New Yorkers. We believe that increasing diversity and representation on those boards and councils will be critical to further inform the decisions that come out of those important bodies. We will continue to partner with our colleagues and the council operations team to ensure that we try and do our best to increase diversity as much as possible. I have a quick update from the office of Gun Violence Prevention. Many of you all may have read in the State of the State 2024 book the Governor announced major expansions to combat gun violence. We were particularly excited to see the Office of Gun Violence Prevention here within the Department of Health highlighted within that book. As you know, there was a state agency, Division of Criminal Justice Services that is mainly responsible for public safety strategies and efforts. As you all know, the Governor had announced through Executive Order declaring that gun violence is a public health crisis and specifically, created the Office of Gun Violence Prevention within the Department of Health to undertake a preventive public health approach to mitigating and ultimately reducing gun violence. As announced in the 2024 State of the State book, many of you may be already aware of this and invested, as many of you have hospital-based violence mitigation programs already in place. The State of the State announcement, one of the pieces was talking about a New York State Health Systems for Gun Violence Prevention Task Force. It will be comprised of representatives from hospitals, hospital systems and hospital associations that will contribute to conversations impacting hospital-based setting. The establishment of this task force is underway. The intention is that this membership will build support from leadership and hospital-based settings to promote implementation of recommended solutions to address and mitigate gun violence. Also, in the 2024 State of the State, the Office of Gun Violence Prevention, in partnership with stakeholders and experts across the Department of Health will develop a syndromic surveillance system to house data and publicly put out data related to firearm injury. The Office of Gun Violence Prevention will manage the data, maintain the outputs, conduct trend analysis, and defend the findings in a public dashboard, which I know many community stakeholders have asked about and are interested in seeing. We are very excited to be able to deliver that. We continue to partner with Amir's team and the Office of Health Insurance Programs to provide guidance and technical support to clinicians and community organizations related to hospital violence intervention programs. We are continuing that work. Lastly, from the Office of Minority Health and Health Disparities Prevention, I wanted to provide a quick update on the mentorship in medicine and other health professions program. This is a program that specifically supports activities and approaches designed to contribute towards the reduction of barriers by promoting an increase in the number of economically disadvantaged and underrepresented minority students who would like to pursue professional careers in medicine and health related areas. We are delighted to share that we issued award and non-awardee letters to applicants in recent weeks related to the mentorship and medicine competitive opportunity. Hofstra University will be implementing the initiative for the next five years, starting this May. This program will be supported by local assistance funding that is coming in through the Office of Minority Health and Health Disparities Prevention. This will continue to support existing pathway programs. With that,

I'm happy to close with the update from the Office of Health Equity and Human Rights. I'm happy to answer any questions you may have.

Mr. Kraut Thank you so much.

Mr. Kraut Dr. Soffel.

Dr. Soffel Good afternoon, Tina. It's good to see you. Question about the Health Equity Impact Assessments. Have you started to receive Certificates of Need that include the Health Equity Impacts? What's the status of that?

Ms. Kim Yes. The department has received a number of Certificate of Need applications that came with and required a Health Equity Impact Assessment. The Health Equity Impact Assessment unit within the office is one of various review units within the department that leads to the overall comprehensive review of Certificate of Need application. We are part of the process. We anticipate that in future PHHPC meetings there will be presentation of applications that will include review of the Health Equity Impact Assessment. I am happy to share that we, we are in receipt of Health Equity Impact Assessments from Certificate of Need applications but unable to kind of disclose further. There's not just our review, but there's other reviews that are happening concurrently for those applications. They are very much in process.

Mr. Kraut Dr. Soto.

Dr. Soto Thank you very much for your presentation. I have a question on the last item that you brought up in terms of support to increase the diversity of physicians and health care providers from disadvantaged and diversity groups. Do you have a sense what is the criteria of the individuals who will be eligible for this? In part, the reason I'm asking you this, because I used to direct science technology entry program that right now is being sued because of the eligibility requirements for that program.

Ms. Kim I can certainly circle back with you on specific eligibility criteria when it comes to individual applicants. The focus of the mentorship in medicine and other health professions program is specifically to support institutions that are kind of increasing students' awareness and pursuit of careers in health care, including behavioral health, STEM education programs,, science, technology, engineering and mathematics. I know that there's a specific focus on which types of programs fall under the parameters of this mentorship and medicine program. I'm happy to circle back with the specific eligibility criteria.

Mr. Kraut Thank you very much, Ms. Kim.

Mr. Kraut I'll now turn to Dr. Boufford to give us a report on the activities of the Public Health Committee.

Mr. Kraut Dr. Boufford.

Dr. Boufford I'm not going to repeat what was said earlier by Dr. Bauer, but I wanted to give you a little bit of background because I think this will be coming back to the council. Just historical background. The first thing is that this is the fourth cycle of the prevention agenda. It initially started 2008, and it's been done in sort of four-to-five-year blocks. The current sort of approach is 2019 to 2024. The next one will be what we're planning now is

will be 2025 to 2030. That's important. There have been changes during those cycles, I think from the initial cycle of having ten goals, the current one is five and truly tried updating the objectives, etc. There has been also a really effective dashboard on reporting. The key partners in the currently operate prevention agenda have been local health departments working with hospital leadership, bringing as many people locally as they can, as many stakeholders to the table, including business, nonprofits, academic institutions, etc. The goals for the current prevention agenda were really based on the state health assessment, which identified four basic goals. The fifth one was added, which were the causes, the highest causes of preventable mortality in the state. They were picked as, chronic disease, healthy and safe environment, healthy women, infants and children's and communicable disease prevention. Because of working directly with the Office of Mental Health, OASAS on the drug policy and NYSOFA. In the current model, the fourth goal was added, which was promoting well-being and preventing mental health and substance use disorders because the Department of Health doesn't have authority over that activity. The health department and OASAS joined together, really starting back in 2019 or 2018 before the COVID. Now, all this was sort of interrupted in COVID, although interestingly, and I think we've had these presentations in the Public Health Committee, local health departments continued to report what was going on in addition to COVID, and we had some panels and other things going back a couple of years. That's kind of the way of background. This next cycle would be a new sort of six-year cycle, which we would be creating, really by the Fall of 2024 ideally to have guidance drafted that could then go out for whatever implementation is going to take place. Over the last few months, and I want to give credit to my colleagues on the Public Health Committee who've been working over the Summer and over a number of times during the Fall with the Ad Hoc Committee. What we've been doing is reviewing the priorities that exist, progress against goals and metrics and the implementation mechanisms for the current prevention agenda. We've had updates from staff. We had panels from our partner agencies; NYSOFA, OMH and OASAS. I want to mention the Department of State that's been particularly interesting and involved around the economic development issues on, smart growth as well as environmental justice. They've been very involved. We also had a panel with NYSACHO and Greater New York and HANYS who really talked also about the prevention agenda. We invited them to really talk about strengths and weaknesses, because we want to inform, the design of the next generation. Our last meeting before Christmas we had a presentation from, the Master Plan on Aging, which also has a subcommittee on prevention and health, which we're watching that crosswalk because one of the goals of the prevention agenda initially, which I think we all agreed was not well met was really incorporating aging in the various objectives. There was an objective there for over 50 but that's not the group that we're talking about in the master plan. The mechanism was each local partnership identifies two of the five areas of the state goals that they wish to work on and address a health disparity. I think there's been a good sense of what worked and what didn't work. Generally, I think it just to summarize the response from the various meetings and discussions we've had is the prevention agenda was seen to be very important and very positive in raising the visibility and importance of prevention. Many of our sister agencies indicated that they have started units to focus on prevention within mental health and behavioral health and others that they had not had prior to their collaboration on the prevention agenda. There also have been some counties and local partnerships with counties and hospitals that have been very successful bringing multiple stakeholders together, getting community engagement and really working through the entire process, which is setting goals. I'm looking at Dr. Watkins. Setting goals, designing evidence-based implementation and evaluating that implementation. It's been a problem for others. It's been an unfunded initiative. That's been one of the issues. Similarly, one of the areas that had begun to happen but wasn't as fully developed as we hoped going forward. The new

model was really linking the local infrastructure on area offices on aging, the local and regional infrastructure, which is basically sort of federal pass through in some ways on mental health and behavioral health with local health departments and having them begin to work together with local health departments and hospitals. Again, as always, things have worked well or not so well. The other, piece of the current activity was really encouraging hospitals and local health departments to work together on submitting their local plan. Using the Health Department's required annual health needs assessment, health assessment and then building together their choices of initiatives, as well as other local issues that they might be working on. After about ten years, we have about a 45% overlap between what's going on between the partnerships between health departments and local hospitals. A part of the question that's here is, is there a more effective vehicle for really pushing that collaboration a little bit more strongly in the next cycle? The last area we looked at was, and I think these are recommendations for change, some of which, link directly to what Dr. Bauer mentioned, that we want to revisit the priorities to see if they are, in fact, the appropriate ones. We want to... Obviously, some of that will come from the updated State Health Assessment, which is just being completed. It's going to be presented at the next Ad Hoc Committee meeting. Total consensus on reducing the number of objectives. Obviously, they have to be revised because they were not... I think, now been fully revised in the last couple of weeks but had lagged. Lengthening the cycle of reporting. A local health department had felt that three-year report was really too short. They wanted a cycle of either maybe annual updates, but a six-year opportunity to really embed the changes they wanted to make. As Dr. Bauer alluded to, greater engagement on the issue of social determinants of health. It's important to realize in public health that the evidence base for social determinants, and I am not talking about social service supports to complex patients. I'm talking about social determinants of health, which have to do with conditions in communities in which people live. Healthy housing is an important issue for a patient that has complexity and is houseless. The issue is, can we deal with policies that fix housing stock in communities or greenspace or other things? Health in all policies. Exactly. What are the other questions going forward because of this interest in broader engagement in social determinants of health is that there has been since 2018 a mechanism an Executive Order that Governor Cuomo issued, and Governor Hochul has actually referred to and endorsed to have all agencies in New York state government look at their policies, their procedures and their contracting relative to the health effects and or the effects on healthy aging. That's sort of been in place since 2018 and was reinforced in creating the Master Plan on Aging that Governor Hochul issued. Obviously that group had been constituted. It was co-chaired by the Commissioner and individuals from the Governor's Office. It was obviously interrupted by COVID. The last meeting was scheduled to be March of 2020 and didn't happen. That mechanism is there. It was a really a focus of a lot of the questions yesterday that the health department and hospitals have a role, certainly a critical role to play. If you're focusing specifically on health problems they have a bigger role, relatively speaking, perhaps then beginning to address some of the broader social determinants, which are very, very important. The discussion we were having yesterday is it's very clear of what they can do. How might they be encouraged to do that again without financial incentives or others. I'm going to continue to make this distinction between social care services and social determinants of health, which are from the point of view of the prevention agenda different. Similarly, how could we bring other agencies in? There was a really nice report on the kinds of evidence base that interventions hospitals can make that health departments obviously can make. We know broader sort of nonprofits are very involved in all this. To deal with policy chains on food, for example, or food security, AG and Markets is an agency that needs to be involved and green space, parks and recreation and others. That's kind of where we ended the discussion yesterday, which I think is really important. I just want to thank my committee members for asking

really good questions. Part of it is really developing this and how will the connections be made and how will the metrics be developed for social determinants focus on a new model of the prevention agenda? We have a meeting of the Ad Hoc Committee on the 22nd of February. I encourage anyone to come. We'll get the feedback from that group, which is officially the sort of public advisory group to the prevention agenda. We've talked tentatively about having another cycle of Public Health Committee and Ad Hoc in April to sort of see where we go with drafting since we need to get some decisions made and bring back to the PHHPC, so that there's plenty of time in the Fall for developing the guidance and issue to get to local leadership. Thank you.

Dr. Boufford I'm happy to take any questions.

Mr. Kraut That meeting in February on the 22nd will be in Albany. I'll repeat that again.

Dr. Boufford Other issue, just very quickly, the Public Health Committee has historically picked an issue of importance, public health issue of importance to work on. You'll recall we really worked hard on the maternal mortality question about seven or eight years ago and I think, can take some credit for launching the focus on maternal mortality after that. We have picked public health workforce not daunted by challenges. This year we heard from the new Office of Public Health Workforce, and we heard from the leadership of that group. I want to mention her name, Keshana Owens-Cody, who presented. She's kind of really organizing her office and presenting her plans for staffing up in some of the areas are going to work on. We're developing that with them. Thank you.

Mr. Kraut Just as a point of history, the last time we adopted the prevention agenda was in 2018. That was to run through the end of 2024. That's the timing issue Dr. Boufford spoke about.

Mr. Kraut Any questions for Dr. Boufford?

Mr. Kraut Thank you. I know this will become... We're going to have to devote a significant time to review that agenda with the full council after its recommended to us after the Ad Hoc Committees meet. That'll probably be early/late Spring.

Dr. Torres I just want to say something. That there are many elements of this that plays into the social care network.

Mr. Kraut It's beyond just the social care. It really goes back to the health, when ee talked about the health in all policies.

Dr. Boufford You're right. I think one of the five areas identified for attention in the new and the proposal that came from the department was really looking at health care quality and access to care. That could align very well. The prevention agenda has historically kind of stopped at the clinical door and tried to deal with the other environmental issues and where people live and go back to but that is on the table for potentially more work in that space in the new proposal.

Mr. Kraut Thanks so much.

Mr. Kraut Dr. Rugge is going to give a report on the Health Planning Committee.

Dr. Rugge Quick brief update thanks to Colleen Leonard and Jeff Kraut on behalf of the planning committee of this council. It was one year ago that Dr. Morley brought to PHHPC concerns raised by SEMSCO State Emergency Care Service Council regarding untoward lengthy delays of offloading ambulances at the ED ramp sometimes for hours. An analysis showed there's a lot of variability across the state. Further analysis showed there were two areas of particular concern that seemed inappropriate to go to the ED; mental health and oral health because it really can't be treated very effectively there. That led to a series of committee meetings, but also committee workshops trying to learn what are the opportunities, what can we learn from elsewhere around the state and around the nation. Starting with Dr. Sullivan as Commissioner of Office of Mental Health, describing CPEP, Comprehensive Psychiatric Emergency Program based on turning 911 calls into 988 calls and instead of simply having the ambulance go to the one place, find a more appropriate and develop a more appropriate setting. That's been supported by gubernatorial support and gradually expanding around the state. Then we came to oral health and hit upon a California example or program with 911 calls for dental problems referred to a dental referral agency and RNs supported by a backup dentist to find immediate care over the telephone and then referral to a more appropriate setting among dental providers. Again, I'm hoping that what happened was the interest of our planning committee that questions were raised. The queries help to guide where to go next with all this. What's been happening for a number of months now is lots of hard work by staff. Coming back to us as the new director of a new bureau for strategy. Of course, Dr. Heslin, looking to prepare a report that would be informative and precedent setting in terms of how we reform the structure and the delivery of health care. This draft report, as I understand it, has three significant components. One is EMS reform, how to make sure that a 911 call simply does not automatically lead to an ambulance taking somebody to the emergency department when it may not be helpful. In this case, Governor Hochul has jumped ahead of us. The executive budget there's a proposal for establishing five EMS zones with oversight by an EMS statewide task force, supported by appropriate reimbursement through the Medicaid program. Using this to establish a paramedic program the ET3 federal program, of which the New York state was a participant was canceled by the state in December. Triage and transport. Because there was very little sign up, but now it's been redesigned and reformulated into a state supported state-based system. One that will include the use of community paramedicine with in-home assessments, not in hospital assessments. That's number one. Number two, continued BHS reform, behavioral health reform. The question is how can PHHPC and its planning committee be helpful in understanding what new twists could be applied to their program and be supportive? Number three is back to dental care. How can we develop a triage system for a new referral service? How can we develop new forms of caregiving, specifically considering the use of dental therapists and dental assistants in new ways? What we're doing in primary care with physician assistants. Developing partnerships for referrals to federally qualified health centers and dental training programs, dental schools. With all this, the report is in draft. It is about ready within days to go to senior leadership within the Health Department and other agencies. With a timetable of hopefully March, perhaps more like April, hopefully not longer than that. Then to come back to the Planning Committee and to PHHPC for consideration and review and for the proposals. Along with that major priority is to say this was a start in terms of how this council can be helpful in terms of restructuring our delivery system. What's next? Starting at the unloading offloading ramp of the E.R. is kind of poetic, I like to say. Now the question is, where do we go next by way of making health care more effective given all those new technologies, all the new programs we have been undertaking? Hopefully along the way, the work of us as PHHPC members has been helpful in some way in terms of stimulating interest, sparking this discussion, and that we will be helpful going forward in identifying new opportunities and helping our real experts, the people working hard at this

to explore the options and settle on new courses. Let's hope we will work together and realize that we are the Public Health and Health Planning Council.

Mr. Kraut You know, it's interesting I'm going to talk a little about this. We're going to devote a session of the full council to obviously the prevention agenda, as I said, and another session to the recommendations coming out of the Health Planning Committee, which I will adjust the agenda to make sure we give it ample time to be discussed.

Mr. Kraut Ms. Monroe.

Ms. Monroe As Vice Chair of the committee I've really been pleased along with John about the progress of this report. I am as enamored as anyone about new ideas to address the problem. I also want to make sure this report defines the problem. Is it the same everywhere? Is it regional? Is one region stronger than another? Is it children? Is it adults? Is it Medicare? Is it Medicaid? Who are the payers? In addition to great new ideas about fixing the problem, I'm really hoping that this report will also define and describe the problem. I wanted to add that to what John said, because that's kind of our ying and yang of the Health Planning Committee. I don't expect a response today, but I do hope that there's a true description and definition of the problem.

Dr. Strange I will respond. That might take another year.

(Laughing)

Dr. Strange I will say is very important is that because we did this, even though the report isn't out, when you look at the executive budget, we had five scope of practice issues in this year where we had thirty last year. Large EMS package. A very strong section in dental. We focused on something with Public Health Council. We brought together and used Public Health Council as a convening tool, gathered information. Got outside input. Amazingly, two of five major areas that are in executive budget are there. I would say congratulations.

Mr. Kraut Thank you.

Dr. Rugge Another quick observation that health care is like the same everywhere. I mean, the EMS squads are so different from one another, so fractured, so diverse, profit/not for profit, government based, private based and working together to how to regularize and more standardization so we have one standard of high quality everywhere. That's our project.

Mr. Kraut That's great.

Mr. Kraut Thank you very much.

Mr. Kraut I'm going to turn to Mr. Holt now to give a report on the Codes, Regulation and Legislation Committee.

Mr. Holt Good afternoon. At the February 8th committee meeting on Codes, Regulations and Legislation, we reviewed six codes, one for emergency and full adoption, two for adoption and three for information only. They were all recommended for adoption by the full council. The first one was for both emergency adoption and full adoption trauma centers, resources of optimal care of the injured patient. Department presented the trauma

centers resource of optimal care of the injured patient, proposed regulation to the Committee on Codes for emergency adoption and adoption. They are available to the council should there be any questions of the members. I so move.

Mr. Kraut He so moves.

Mr. Kraut I have a second Dr. Berliner.

Mr. Kraut Any questions from council members?

Mr. Kraut I'll call for a vote.

Mr. Kraut All those in favor?

All Aye.

Mr. Kraut Opposed?

Mr. Kraut Abstention?

Mr. Kraut Motion carries.

Mr. Holt Next for adoption at this morning's meeting, we had the adult day health care code presented by Ms. Heidi Hayes, Ms. Stephanie Paton and Ashley Corcoran of the department. They presented that proposed regulation to the Committee on Codes. They are available to the council should there be any questions. I move the adoption of this code regulation.

Mr. Kraut I have a motion.

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

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 Opposed?

Mr. Kraut Motion carries.

Mr. Holt Third, we had the hospital in a nursing home PPE requirement. Jaclyn Sheltry and Jonathan Karmel of the department presented the hospital and nursing home PPE requirements and proposed regulation to the Committee on Codes for adoption. They're available to the council members should there be any questions. I move the adoption of this regulation.

Mr. Kraut I have a motion.

Mr. Kraut May I have a second?

Mr. Kraut Dr. Yang.

Mr. Kraut Any questions?

Mr. Kraut All those in favor?

Mr. Kraut Opposed?

Mr. Kraut Abstention?

Mr. Kraut The motion carries.

Mr. Holt Finally, we had three, codes for information only for the council, general hospital, emergency services, behavioral health. The statewide health information network of New York, Adult Day Health Care and General Hospital Medical Staff Recertification. Those will come back to the council for further consideration at a future date. That completes this morning's report.

Mr. Kraut Thank you very much, Mr. Holt. For those of you who were present for Codes, there was a very robust conversation on them. It was a very good meeting.

Mr. Kraut Mr. Robinson is going to give the report of the actions of Establishment and Project Review Committee.

Mr. Robinson Thank you very much.

Mr. Robinson As Mr. Kraut said at the beginning of the session, we go through batches at full council for this application. One last call for anybody that wants to pull an application out for more extensive discussion. Otherwise, I'm going to proceed with the batches.

Mr. Robinson Thank you.

Mr. Robinson For these first two, I'm asking Dr. Kalkut or leave the room. Calling application 231332C, NYU Langone Hospital, Long Island, Nassau County. I'm also noting an interest by Dr. Lim to certify a new extension clinic for ambulatory surgery at 1440 Northern Boulevard, Manhasset. Department and committee recommend approval with conditions and contingencies. Application 231348C Long Island Community Hospital and NYU Langone and Suffolk County to certify a new extension clinic for ambulatory surgery at 196 Main Street in Patchogue. Also, the department recommends approval with contingencies, as did the committee. I move those two applications.

Mr. Kraut I have a motion.

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

Mr. Kraut Any questions?

Mr. Kraut All those in favor?

All Aye.

Mr. Kraut Opposed?

Mr. Kraut Abstentions?

Mr. Kraut The motion carries.

Mr. Robinson Please have Dr. Kalkut return.

Mr. Robinson Next batch for applications for diagnostic and treatment centers. Application 231299C, Weill Cornell Imaging at New York Presbyterian in New York County. Interest by Dr. Lim. Certify a new imaging extension clinic at 575 Lexington Avenue. Department and committee recommend approval with conditions and contingencies. Application 232063C, ODA Primary Health Care Network Inc in Kings County. Noting an interest by Dr. Kalkut. Certify a new extension clinic at 251 Wallabout Street, Brooklyn, and certify medical services, notably primary care, medical services and other medical specialties and optometry. The department and the committee recommend approval with conditions and contingencies. Application 231308C, New York Presbyterian Westchester, in Westchester County. Certify new extension clinic for ambulatory surgery at 1111 Westchester Avenue White Plains. Department and committee recommend approval with conditions and contingencies. 231311C, Samaritan Medical Center, Jefferson County. Certifying five psychiatric beds and performing requisite renovations. Department and committee recommend approval with conditions and contingencies. Application 231326C, Auburn Community Hospital in Cayuga to certify cardiac catheterization and PCI and perform renovations to an existing interventional radiology suite. Department and committee recommend approval with conditions and contingencies. Application 231351C, Saint Charles Hospital in Suffolk County, certifying cardiac cath, adult diagnostic cardiac cath, electrophysiology and cardiac cath PCI and perform renovations to create a new cardiac cath lab. Department recommends approval with conditions and contingencies, as did the committee. Application 231261C, Weill Cornell Imaging at New York Presbyterian and Kings County to certify a new extension clinic.

Mr. Robinson Thank you.

Mr. Robinson Brooklyn. Go Brooklyn!

(Laughing)

Mr. Robinson Department and committee recommend approval with contingencies. I don't know why my tongue tied up on that. 232124C, Community Health Center of Richmond Inc in Richmond County certify a new extension clinic located at 104 New Dorp Plaza in Staten Island. This is a HERSA funded safety net application. Department and committee recommend approval with conditions and contingencies. I move that back.

Mr. Kraut May I have a second?

Mr. Kraut Dr. Berliner.

Mr. Kraut Any questions?

Mr. Kraut All those in favor?

All Aye.

Mr. Kraut Opposed?

Mr. Kraut Abstentions.

Mr. Kraut The motions carry.

Mr. Robinson Batching applications for ambulatory surgery centers. 222044B, Sorin Ambulatory LLC doing business as Sorin Ambulatory Surgery Center in New York County to establish and construct a multi-specialty ambulatory surgery center at 120 Wall Street. An interest by Dr. Kalkut. Approval is recommended with conditions and contingencies with an expiration of the operating certificate five years from the date of issuance. The committee similarly recommended that. Application 231114B, Prime MD Center LLC in Nassau County. Noting interests by Dr. Lim and Mr. Kraut to establish and construct a new DNTC at 1,000 Railroad Avenue and Woodmere. Department and committee recommend approval with conditions and contingencies. That's the batch that I move now.

Mr. Kraut Doctor Lim, before I do it, are you abstaining on it?

Dr. Lim No, I'll be voting.

Mr. Kraut You'll be voting with an interest.

Mr. Kraut I have a motion.

Mr. Kraut May I have a second?

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

Mr. Kraut Any questions on this?

Mr. Kraut All those in favor?

All Aye.

Mr. Kraut Opposed?

Mr. Kraut Abstentions?

Mr. Kraut The motion carries.

Mr. Robinson Thank you.

Mr. Robinson 231361B, Title Home Dialysis in Kings County. Noting an interest by Mr. La Rue. Establish and construct a new DNTC at in Brooklyn and certify home hemodialysis training and support and home peritoneal dialysis training and support. Department recommends approval with conditions and contingencies, as does the committee. I so move.

Mr. Kraut I have a motion.

Mr. Kraut Do I have a second?

Mr. Kraut Mr. Thomas.

Mr. Kraut Any questions?

Mr. Kraut All those in favor?

All Aye.

Mr. Kraut Opposed?

Mr. Kraut Abstentions?

Mr. Kraut The motion carries.

Mr. Robinson Mr. Kraut is leaving the room with this next application.

Mr. Robinson Application 231120E, Health Quest Home Care Inc license. The geographic area is broad. This is to transfer ownership interest above the parent level. The department and the committee recommend approval. Madam chair, I so move.

Dr. Boufford Do I have a second?

Dr. Boufford Thank you, Mr. La Rue bumping out Dr. Berliner.

Dr. Boufford Any comments/questions from the council?

Dr. Boufford All in favor?

All Aye.

Dr. Boufford Any opposed?

Dr. Boufford Any abstentions?

Dr. Boufford Motion passes.

Dr. Boufford Invite Mr. Kraut back into the room.

Mr. Robinson Application 232088E, Sheepshead Bay Surgery Center in Kings County. Transferring 5% ownership interest from a deceased shareholder to an existing shareholder. Department and committee recommend approval with conditions. Application 232080B, ALEF Health Center, LLC in Richmond County to establish and construct a new DNTC at 3777 Richmond Avenue in Staten Island. Department and committee recommend approval with conditions and contingencies. Application 232106B, New York Health Care and Wellness in the Bronx to establish a new DNTC at 3005 Grand Concourse in the Bronx. Department and committee recommend approval with conditions and contingencies. 232133B, Nemo Health Inc in New York County establishing construct a new diagnostic and treatment center by converting a private practice at 651 Academy Street in New York, Manhattan. Department and committee recommend approval with conditions and contingencies. I make a motion for that batch.

Mr. Kraut I have a motion.

Mr. Kraut May have a second?

Mr. Kraut Dr. Berliner.

Mr. Kraut Any questions?

Mr. Kraut All those in favor?

All Aye.

Mr. Kraut Opposed?

Mr. Kraut Abstentions?

Mr. Kraut The motion carries.

Mr. Robinson Thank you.

Mr. Robinson Application 202035E, Hilaire Health Care Network LLC doing business as Pine Forest Center for Rehabilitation and Health Care in Suffolk County to establish Hilaire Care Network LLC as the new operator of the seventy-six-bed residential health care facility located at 9 Hilaire Drive in Huntington. Currently operated as Hilaire Rehab and Nursing. Department and committee recommend approval with a condition and contingencies. Application 222260B, Oxford Nursing Home in Kings County. Relocate the facility from 144 South Oxford Street, Brooklyn to a new building to be constructed at 2832 Linden Boulevard in Brooklyn and transfer 15% ownership interest from one deceased member to two existing members. The department here recommended approval with conditions and contingencies as did the committee. Changes of ownership here for Home Health Agency licensure. 222103E, Lynn Care of New York Inc and with a broad geographic service area transferring 100% ownership interest from the current owner to a new shareholder LLC. Department and committee recommended approval. Application 222140E, American Outcomes Management LP, again transferring 100% partnership interest from the current partners to a new LLC partner. Department and committee recommend approval. Application 231216E, Tanglewood Manor Inc a broad service area noting an interest by Dr. Watkins. Transferring 100% ownership interest to a new shareholder LLC. Department recommends approval as did the committee. 232021E, Ideal Care SP LLC a broad geographic service area. Transfer 73% ownership interest from one withdrawing member and one existing member to two existing members and one new member. Department recommends approval as did the committee. I'll make a motion for that batch.

Mr. Kraut Have a motion.

Mr. Kraut A second Mr. Thomas.

Mr. Kraut Any questions?

Mr. Kraut All those in favor?

All Aye.

Mr. Kraut Opposed?

Mr. Kraut Abstentions?

Mr. Kraut The motion carries.

Mr. Robinson Thank you.

Mr. Robinson These are certificates of amendment for the certificate of incorporation. Lake Shore Hospital Foundation Inc. Department and committee recommend approval. Open Door family Medical Care Inc. Department and committee recommend approval. Certificates of amendment of the Articles of Organization for Pontiac Nursing Home LLC. Department and committee recommend approval. And recently stated Certificate of Incorporation for the Guidance Center of Westchester Inc. Department and committee recommend approval. I move that batch.

Mr. Kraut I have a motion.

Mr. Kraut I have a second, Mr. Thomas.

Mr. Kraut Any questions?

Mr. Kraut All those in favor?

All Aye.

Mr. Kraut Opposed?

Mr. Kraut Abstentions?

Mr. Kraut The motion carries.

Mr. Robinson That concludes the report of the Establish and the Project Review Committee.

Mr. Kraut Thank you very much, Mr. Robinson. Very efficiently done.

Unknown Take a breath.

(Laughing)

Mr. Kraut Nobody go anywhere if you can hold on. We are going to go into an Executive Session in a moment to discuss a health personnel matter. I want to talk about the retreat for a second to give you a sense of it. It's scheduled for the evening of May 8th, where we would arrive and have dinner and have a speaker. I'll talk a little about that in a moment. Spend the entire day on Thursday starting at about breakfast going to the end of day. The issue is what do we kind of focus in on and use this productively? There are so many subjects to speak about just look at today's discussion. Recognizing this is public health and health planning. There are two things. One, we are going to spend time on public health and the prevention agenda in the course of a meeting. I promised one of the

meetings has to go over the things Dr. Boufford and Dr. Bauer spoke about. The second is we're going to come back and look at health planning and the recommendations here. Knowing those things are going to be discussed in a meeting, I kind of move those to the side. If you remember, we've been trying to hold a retreat for quite a bit of time. A lot of you wrote to me and commented as we started thinking about the next one. I had all your comments from the previous ones, which I reviewed. There was a consensus, at least at the time is let's focus on issues that are going to come before us and that we've had trouble having... We've never had adequate time to understand. One of them is the changing nature of health care, the different models, the different organizational structures, the different governance structures. Dr. Berliner gave a great talk many years ago about all these changes that were occurring. I think we would start with a speaker. I don't know if it'll be Dr. Berliner, but, you know, maybe. He volunteers. He's cheap at least, or inexpensive.

(Laughing)

Mr. Kraut You know, the other thing is the Commissioner is going to be joining us and obviously wants to talk about the policy agenda for the Department of Health and the role of the PHHPC. One of the things that we approved many years ago and we've never gotten feedback on...and in light of certain the hospital closure activity in our marketplace is the evolution of the kind of freestanding emergency departments and they're evolution. Because you've also approved them with beds and you've approved them with other services attached thinking that we kind of review the regulatory framework, but also invite in two or three operators, some downstate, and make sure we have rural, so we see different dimensions. Ms. Monroe kind of made this a really important theme. She's absolutely right. Just don't come and talk to us. We want to make the presentations tight and then let us ask questions and get involved in what the implications might be for future projects that are coming our way or, frankly, regulatory reform, which I'll come back to in a moment. The second issue is the issue of aging, but not as wide ranging as Mr. Herbst provided. I mean, we have struggled with long term care projects coming in here, specifically character and competence. The structure that's happening, the current looking and investigations that are going on, not to say we're going to talk about the investigations, but they've raised a lot of issues. How is that going to come back here when we look at establishment into the future? To structure a conversation about that. I think the Medicaid waiver, as you heard today has far reaching consequences, whether from now until May I don't know if much will change from what Mr. Bassiri said, but really focusing in on those aspects of the waiver that have implication in regulation or health equity. I think the department and some of the staff have to kind of work to focus the question. I think for us to sit and not have a conversation about how we're bridging the equity issue from the regulatory framework. Dr. Soffel brought up the health equity impact. We may have one by then. It may raise issues of the process we're going to use. I'm not sure exactly how we would do that, but I think that merits conversation. Spend the last two hours, if this is structured correctly to go through some of the regulatory reforms that have been proposed in CON and the operations of the council. We have new mandatory members that are supposed to be appointed. I doubt they'll be appointed by the time we meet, but if they are identified. I'd certainly invite them as guests, as we would members of the public so they kind of here this. Spend the balance of time on what's focusing the PHHPC agenda for the upcoming year to eighteen months. For us to look at things that we've said, this is like ridiculous. We should change this rule or regulation and try to have stuff for us to read beforehand, focus the questions that we're going to try to come out so we're clear about at the end of this agenda. What we had done last time is we created an agenda of items that we wanted to look at during following the retreat and then we ran into COVID. COVID

opened up a lot of issues. What I would like to do is I need to have more conversation with the department, because I've gotten some feedback but not broad. I'll reduce this in a note to everybody to kind of comment and give out a draft agenda. I'm very mindful of what Ms. Monroe said is we don't want just people talking to us without the opportunity to discuss among ourselves. How does that feel as a good starting point?

Mr. Kraut Dr. Bennett.

Dr. Bennett as I listen to what you said, I'm trying to think of how much time all that's going to take.

(Laughing)

Mr. Kraut Yes, I've worked out some timing issues.

Dr. Bennett Talking about a lot of things.

Mr. Kraut Well, one of them may drop out.

Dr. Bennett Question without any firm opinion. Is it too much in one day?

Mr. Kraut Well, I honestly I've heard myself say it and as I said it, I think it's too much. I'd rather on the side of leaving time for conversation than packing this. If you find this beneficial, we might be able to have a second retreat without necessarily having an overnight, because there is, you know, obviously an expense and logistics to do this. If we find that if we then say that then what we need is part of our agenda setting a kind of a Spring and Fall meeting, then that's what we do.

Dr. Boufford One, I think it sounds like you've touched on the key points. I think there is one other source of information which might be areas we've worked on in the past that didn't go anywhere. I think some of the world is changing, but this sort of integration, the Health Planning Committee had done work on integration of behavioral health and sort of physical health care and dealing with the regulatory implications of that or legislative implications. It kind of hit the wall at that point. There's still a lot of conversation. Some of these pilots are getting over that barrier. I think the issue of routine questions of why we can't do better there. Revisiting that that happened. That was one thing. I'll think of the other one in a minute.

Mr. Kraut To that point actually---

Dr. Boufford Dr. Boufford speaking away from mic.

Mr. Kraut Yeah.

Dr. Boufford --- I think.

Mr. Kraut Actually, I think Dr. Lim, the most recent exchange on the regulatory framework to permit this to happen. During COVID we had tremendous flexibilities to do things. We lost those. Some of those need to come back. I think within the context of regulatory flexibility may be looking at how you try to do that. Again, we have to just the timing.

Mr. Kraut Dr. Strange.

Dr. Strange I think there's a lot on that agenda. One of the overarching elements of this whole thing and the commission brought this up is the workforce issue. Because none of this can be accomplished without workforce being addressed in this whole thing.

Mr. Kraut Again, I'm trying to focus the things under our purview. This council every year has made a statement that what we would love to do is have a joint task force with state education to address those issues. I would absolutely endorse that if there was a practical pathway to do it. I think that has a legislative directive to do. Maybe that's what comes out of our agenda setting is that this becomes a high priority issue for us to not be passive, but maybe to be more focused in advocacy.

Mr. Kraut Yes, Dr. Berliner and Dr. Kalkut and then Dr. Soffel.

Dr. Berliner I must say that I stand behind no one in my support for public health and the public health agenda and the public health part of PHHPC.

Mr. Kraut Right.

Dr. Berliner We do have a health planning component also that doesn't directly relate to public health, although it's adjacent to it. What we found during COVID was that our health system in New York State was both fiscally and structurally unprepared for a pandemic. To my knowledge, and I may be wrong about this. If it happens tomorrow, we're back in the same position. If it's not a respiratory condition, we may be in even worse condition. I think it would be useful for us to discuss what could New York do ro deal with a potential pandemic? Does it need more beds? Does it need different beds? Does it need different health care settings? This directly relates to workforce. Y

Mr. Kraut Like I said, I just fill up days.

Dr. Berliner Absolutely. We can look at the small stuff, but we should also kind of not ignore the big stuff.

Dr. Kalkut I agree that what you've already went through is probably too much. I'll just pile on for a moment. Came up a couple of weeks ago and I think it's come up repeatedly is the technology and space requirements things moving into the ambulatory space. Surgery centers we talked about two weeks ago, but we've talked about before. What's happening with DNTCs. Again, I think would be important. Maybe that's in phase two or the second day or the fourth day or the two weeks.

(Laughing).

Dr. Kalkut I think all of that and I think the technology is going to drive this further and further out of the hospital into the community.

Dr. Soffel Thank you.

Dr. Soffel As the newest member of the council until we get our new members, I want to sort of reflect on what has been the most challenging and frustrating for me as I have learned the role of this council. It's kind of interrelated. The first half of it is how the department defines need when we are looking at Certificate of Need and that that's in many cases a kind of mushy, not terribly well defined exercise that especially as we see

emerging types of businesses coming out into the health care sphere that we don't have a good criteria for evaluating whether those services are actually needed and how they reflect and respond to communities. Sort of the flip side of that is we look at each Certificate of Need on its own. We don't seem to have an opportunity to step back and look at a bigger picture, a broader context. Where is the health care delivery system in New York State going? Is that where we as a council believe it should be going? How do we affect that process of change? I don't quite know where that goes in the agenda, but it feels to me like how PHHPC can effectively respond to changes in the delivery system and provide our wisdom and insight into where it should be going.

Mr. Kraut I think you've expressed the struggle we've had. I mean, it's not just being a new member. I mean, we've always had to contend with that, but it is an issue. That's why I'm trying to focus it on areas that we absolutely have impact as opposed to where we want to have impact. That's the challenge within the time frame. It's not to say we wouldn't take that up. I think that's our objective long term.

Mr. Kraut Dr. Boufford.

Dr. Boufford I want to go back to Howard's intervention on emergency preparedness, because we spent a lot of time with all these repeated emergencies whatever's. Just going back again to what we have done at one point when we did a sort of review with our colleagues from Primary Care, Public Health and others around COVID response. The results of that review were that it was totally hospital focused. There were other issues that should have been dealt with. I am assuming that there has been an after-action discussion which we've had not reported to us. It might be just to bring Howard's point concretely. It could be in one of these meetings. It doesn't have to be on the retreat. I think we haven't heard the after-action results of what happened as a consequence of what we learned from COVID about planning for the next time?

Mr. Kraut I think you'll find that at least one aspect of the system, the kind of the emergency first point to contact drills is pretty ready if that happens again. The issue is what we don't control is the government's response to it. I even suspect that'll change relative to other.

Mr. Kraut I'm going to get it out. You'll have an opportunity. I'll reflect on some of the comments. I'll send something in draft once I've had an opportunity to sit with the department.

Mr. Kraut I got to move on because we're going to lose. We have to make a vote.

Mr. Kraut The Ad Hoc Committee to lead the State Health Improvement Plan is going to convene in February on the 22nd in Albany. The next regularly scheduled committee day is March 28th. The full council is going to convene on April 11th. Both meetings again will be held in Albany.

Mr. Kraut I'd like to adjourn the public portion of the Public Health and Health Planning council meeting and have a motion to adjourn and then convene an Executive Session to consider a health personnel matter.

Mr. Kraut May I have a motion?

Mr. Kraut I have a second.

Mr. Kraut All those in favor?

Mr. Kraut We're going to adjourn the public session.

Mr. Kraut We are now going to go into Executive Session.