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TRANSCRIPT

Mr. Kraut If everybody could find their seats, we'd like to begin. I think we're in good shape. Good morning. I'm Jeff Kraut, the Chair of the Public Health and Health Planning Council. Today we have an unusual meeting in that it doesn't occur very frequently. The council was established about 111 years ago. This is the second time in its history that we've departed from our regular meeting schedule to hold what we call an educational session here. I'll go through some of that today. I want to welcome the members that are here. We're also joined in addition to the members of the council today we're also being joined by five of the six members who have been nominated to join the council. We were here last evening. We got to meet everybody. I want to thank also the Commissioner and the department for making today available to the council. This, as you could imagine, took an enormous amount of work to craft an agenda, get everything approved, the presentations, the presenters coming today. I want to give a particular thank you to Colleen and Michael and Jacob for dealing with the logistics and the state bureaucracy that gets the permissions to allow us to have today's meeting. I did not do that thanks as best as I could, because the effort that it took to have this is tremendous and really want to thank you for doing it. Today's meeting, and I want to thank the members of the public who also chosen to join us as well. Those of you who are participating by Zoom. The meeting is being webcast. It's going to be available on the department's website for viewing in future days. Like all of our meetings, we need to be very mindful of not speaking over one another so we can be heard. This is a little different sound system than we are used to. We can only really have one person's mic on at a time. If not, we get feedback. If you could make sure your mic is not on while our speakers are talking. That would be tremendously helpful. Kind of laying out some objectives for what we're hoping to accomplish here. I mean, the general objective of sessions like this is to become better informed in order to discharge the responsibilities of the council that's basically set forth in Section 225 of the Public Health Law and in specific areas of Articles 28, 36 and 40. We have four committees. Establishment and Project Review that reviews CON submitted by licensed facilities. We have the Public Health Committee that advise the Commissioner with respect to matters dealing with public health. Also responsible among its many responsibilities is the review and approval of the prevention agenda. Other documents that frankly help the department become nationally accredited for the work it does. We have a Codes and Regulations Committee that adopts and amends the Sanitary Code and the regulations pertaining to the construction, operations, public need, establishment of licensed health facilities. Our Planning Committee has a very broad agenda advising the Commissioner on matters regarding the organization and delivery of health services. I'll come back to. Lastly, the Health Personnel and Interprofessional Committee that relates to hearing complaints by licensed health providers who have had their hospital privileges terminated, suspended or denied. That's kind of our charge. Within that charge, there's this tremendous flexibility to a great extent. As I said, we were established actually 1913, not 111 years ago. 113 years ago. Our roles and responsibilities have evolved as the health care has changed. Our most recent transformational effort occurred in 2010 when the Public Health Council was merged with the State Hospital Review and Planning Council to form the Public Health and Health Planning Council. Over the years, we've consistently taking time out periodically to review our processes and our approach and in the interpretation of the statutory responsibilities that does respond to the changes in the

organization and delivery of care. We've been involved in advocating and ultimately changing regulations when we see the need to. The last time we had a session like this was back in 2017. We walked out of that session with an agenda to work on improving public engagement, public involvement, public comment. We streamlined the CON process, well, not streamlined it as much as we did. We made it publicly available putting it on a platform for both providers and the public. We heightened and raised awareness of issues regarding Medicaid access, incorporating that into some of our reviews. We focused on maternal mortality that eventually ended up into the state's plans on how to tackle that. We've brought in issues on health equity alignment with the prevention agenda that ultimately found its way into new regulations that dealt with health equity, impact assessments and bringing that perspective into our deliberations. We've looked at character and competence in establishment, particularly issues about nursing home quality. That ultimately came into our reviews of DOH's policy on how they review applicants. We've looked at the CON process that kind of resulted in some streamlining, the changing of some thresholds and the development of new regulations. Our meeting schedule doesn't typically permit us to have in-depth discussions with DOH staff about policy and planning and regulatory issues. I don't know if the public is fully aware of the work that's done here. Prior to every meeting, we receive a... I'll use the anachronistic term book, but a PDF that is a minimum of 200/300 pages, sometimes exceeding that substantially. The requires us to read and get all the background information in order to walk into this room to be informed. We really don't have enough time sometimes during the regular course of our deliberations to take a pause and ask some questions and go more in deep into issues that are coming before us. As I said before, I think that that's why the whole focus of today is to become educated, to have a conversation among ourselves. It'll permit us today to listen, engage with the presenters in a discussion. We just need to be more informed to permit us to be the best we can to do our work on behalf of the State of New York. Now, I'd like to end the day with an objective here to come away with a summary of items that's going to shape our committee agenda in the months, and frankly, probably the years ahead. It's aligned with the DOH priorities. We do not do this in a vacuum. We also understand that there are other planning and efforts going on. The New York State Master Plan on Aging, the New York Commission on the Future of Health Care that is looking at transformational changes to ensure that the limited resources are just deployed for the maximum benefit and the resiliency for the health care system in New York. We can be complementary to those efforts. We're not directly involved in them. I'm sure they'll inform our conversations when their reports became public. We need to focus on those things that are in our purview. We have among our authority. There's a section of the Public Health Law 224B that we are required to undertake a comprehensive review of regulations and council procedures and make recommendations to the Commissioner and the department every five years. The last time we basically did that was back in 2017. We had a deadline. Actually, it was a 2016 we were supposed to do that. That was a charge when we merged councils to do that every five years. I hope we're going to discuss how to best use our committees to follow up and engage in the meaningful activities that strengthen New York's health care delivery system to evolve and be responsible to the identified health needs of our communities and the health policy agenda of the department and the state of New York. I can think of no better way to start that conversation by introducing our Commissioner, James McDonald, Dr. McDonald, to kind of offer us some of his thoughts on issues that are coming before the department and how we might be able to help and shape those conversations.

Mr. Kraut Commissioner, I'll turn it to you.

Commissioner McDonald Thank you, Jeff.

Commissioner McDonald It is great to be here today. I want to thank everybody for coming. I know it's no small thing to actually give up time and spend a whole day with us. You know, I really appreciate the sacrificial time you spend on the council. Today in particular, it's a wonderful time for us to interact with each other. I do want to thank everyone who made this possible. It's really a lot to put this together. Really appreciate all the staff and all the work they did to make this happen. I'm going to go through some slides and really just hit some key concepts. Maybe, perhaps some overarching concepts that we can use to kind of just frame our conversation a little bit today. We feel like we're at least coming from the same point here. It's always a bit of an adventure when I share the screen. See if I can get this to actually get into presentation mode.

Commissioner McDonald First victory of the day. There we go.

Commissioner McDonald I'll start you off with a question first. It's funny. We use terms all the time, and I don't know that we always have the same meaning when we talk about certain words. I thought it'd be important to start with how does the department health look at the word health. I'm not asking anybody to define it for you. Met with the leadership team over the last several months. This is the definition we came up with. It's optimal physical, mental and social well-being is how we're defining the term health. I think it's achievable. I think it's really important that we have a common understanding of what we're actually talking about, though, when we talk about health. It's interesting. When I think about social well-being it's such a different term now than it was many, many years ago. As we see our population getting more and more isolated yet having more interaction electronically. This is our definition. I want to move to another concept here. One is talking about, you know, I've been the Commissioner now for a little over sixteen months. It was time to work with our leadership team to update our mission, our vision, our values, include our definition of health and really a statement of health equity. One of the things that was brought to my attention was that our previous mission statement didn't have the word health equity in it, which seemed kind of just a disconnect. It was really important for us to walk through, well, what is the mission of the New York State Department of Health? One of the things about me in particular is I like concepts to be simple, easy to understand for everybody, and also that you can remember it after you've heard it once or twice. Our mission is up there. It's to protect and promote health and well-being for all building on a foundation of health equity. I'm going to underscore the metaphor foundation of health equity. It's interesting. I hear a lot of people talk about the lens of health equity as a metaphor. I really don't favor the metaphor lens. Because for me, as someone who wears glasses, I can take them on and take them off, but it's optional, right? In other words, I don't have to. Health equity isn't really optional, is it? It's intentional. It's required. I think it's really important that we have the metaphor correct. For us the metaphor is the foundation. Because you really can't have any structure without a foundation. It just doesn't work. That's the part of the reason why the metaphor is so direct for me. Our vision, a healthy community of thriving individuals and families, our values, public good, innovation, excellence, inclusion, integrity, collaboration, respect. There's our definition of health. Here's our statement of health equity. Health equity is foundational to everything we do to help all people achieve optimal physical, mental, and social well-being. Everyone at the Department of Health shares responsibility for achieving health equity and eliminating health disparities. When I say shared responsibility, I think this is one of the things that extends well beyond the Department of Health. Don't we, as a civilized culture all have a shared responsibility in this space? Isn't our shared responsibility intentional and a requirement and not optional? These are concepts that are near and dear to me, and I hope to you as well. I do want to go over some definitions, some more words. Because I've

used the word health equity a fair bit here, but it's important we have a common understanding of this word as well. Now, in New York State Public Health Law it's defined. I think it's really important that New York State actually define the terms. Shall mean the highest level of health for all people until focused efforts to address avoidable inequalities by equalizing those conditions for health for those that have experienced injustices, socioeconomic disadvantages and systemic disadvantages. This is me quoting the law. I don't remember this easily. Because quite frankly, it sounds very good, but it's just not the way I talk. The definition I have below is just sort of a definition we came up with our leadership team. How would you really describe this to someone if you're talking to them in an elevator? They just asked, what do you mean by health equity? It's really a recognition that health equity is intentional. We don't all have the same starting place in life. We don't all have the same advantages. Everyone deserves a fair and just opportunity for the best health outcomes. That's just a common starting point of when we talk about health equity at the Department of Health what are we talking about? The next term I want to just illustrate a little further. It's just sort of a graphic that just differentiates between equality, which is a term we all use and equity. I think when you look at the graphic on the screen there, you see that everybody has the same resource, right? Everybody's trying to get a piece of fruit from the tree. Everybody's got the same tool to acquire the fruit from the tree. It doesn't really meet everyone's needs. Really, it's just one way to illustrate what's the one difference between equality and equity? Equality is important. They're really just different concepts. I want to make sure we have a common understanding of social determinants of health as well. You know, the legislature defines this life enhancing resources such as availability of healthful foods, quality housing, economic opportunity, social relationships, transportation, education and health care, whose distribution across populations effectively determines the length and quality of our life. I'll come back to this concept when I talk a little bit later about the 1115 waiver. Dr. Berliner did a wonderful job talking about this last night. We spend a lot of money in our country delivering care in examination rooms, emergency rooms, operating rooms, all kind of rooms. Really don't spend a lot of money in care outside of those rooms. Some of this will change with the 1115 waiver, but it's really about optimizing everyone's social determinants of health. One of the ways I think about this is we really all can have the same advantages. There's no reason to compete with each other, right? I think we'd all agree everybody should have good housing. Everybody should have a good education. Everybody should have access to transportation. All these things are things that everybody should have. It's part of being in a civilized culture. I'm going to talk a little bit about health disparities too. We have a common understanding of this word as well. Again, it's another term that we use a lot. The legislature defined this as measurable difference in health status regarding care and quality of care served by race, ethnicity, sexual orientation, gender identity, language other than English, gender expression, disability status, aging population, immigration status, and socioeconomic status. Really, for me, it's about outcomes. We shouldn't be having different outcomes in different groups just because you belong to a different group. We all would agree everybody deserves the same outcomes. I think if we understand the terms. We have a common are saying the word health, health equity, social determinants of health and health disparities. It just helps us when we're talking about things that matter to all of us that we have a common understanding. I want to chat a little bit, though about money. The state's budget recently got approved. We're at $237 billion this year. Just to give you a little perspective, the Department of Health has $101 billion to work with. We're about 43% of the entire budget for New York State. $83 billion roughly is Medicaid. $13 billion roughly the essential plan. Everything leftover we have for public health. A lot of our money is really spent on doing things in rooms. We have what we have to shift it differently here. I'm going to just touch on some current public health challenges and opportunities. Operative word here is some, not all just to give you some perspective on things. It's interesting when

I come to every one of your meetings, you ask me how is the department doing with staffing? I just thought I'd get ahead of it today and show it to you.

(Laughing)

Commissioner McDonald You know, this is broken down by fiscal year. When you see the numbers in the bottom 1 all the way through 25, that's the pay periods. That's the way we look at time. The fiscal year starts in April. If you go back to April of 2021, you see we had a little under 4,600 state employees of the Department of Health. You see when you get to roughly the middle of 2021, we're down to a little under 4,400. If you're just seeing, you know, as you go through we're now up to a little over 4,925. We're definitely adding staff. I didn't show you from earlier from the slide from 2020 but suffice to say we're now about where we were in 2020 a little bit above that and we're adding more staff. You know, I think people are seeing the Department of Health as a safe place to work again, a good place to work. The pandemic took a heavy toll on the department, but there's been a lot of things that have occurred in the department to help us hire people. There's been some changes in the way civil service works. There's been just some other opportunities available. There's been some things done to restructure how we compensate staff. There's been a lot of positive things done to help us be more successful at recruiting. One of the things that I think we just have to embrace, though, is that there was this thing called the Great Resignation, right? When you think about the Great Resignation, what you really saw there was people left jobs generally for other jobs. What that did is it took out a lot of corporate history and corporate memory in every organization. One of the main things I'm focusing on at the Department of Health is keeping people to stay at the Department of Health. You know, we just want to retain people. Quite frankly, we're doing all we can to make our culture very positive, a very welcoming environment to everybody, but just get people to stay in their jobs. Work is important to all of us. I often say we spend the best hours of our day at work. I don't want to go home at night with a little bit leftover in my tank for my family. I want to go home with everything and that's why work/life balance is so important to me and to the department as well. Let's talk about some other concepts as well. You know, Dr. Berliner did a great job last night talking about a lot of things. Very provocative conversation. One of the concepts we talked about is health care in the United States. We spend a lot, but we're not quite getting what other countries are doing. This is a different way of looking at what we're seeing in New York. It's called New York's Health System. We really don't have a health system, do we? I mean, no state has a health system, right? Every state has a health marketplace. You get what you can get through your marketplace. It's no secret our Emergency Department wait times are long. I thank the teams who have been helping us here. Really appreciate the work. You know, star ratings. They're noticeable. We're not leading in this area. In quality some concerns. It's interesting. We have some of the best hospitals that the planet has ever known in history. When you think about that I didn't say best hospitals in the country. We have some of the best hospitals the planet has ever known or seen. When you see different issues with quality that makes you wonder what are we seeing out there? Part of what I'm just trying to like to point out some of this is we have some work to do. We're spending a lot of money, but what are we really getting here? Are we achieving health, that optimal state of physical, mental and social well-being? One of the things I think I can ask you to partner with me on is just ask ourselves do we have regulatory gaps? You're much more than a regulatory body. I'm well aware of that. I think we should at least acknowledge are the regulatory gaps. Here was an example that I thought was just kind of interesting. When a physician who's engaged in misconduct is employed by a third party under the sections of the law, such as medical college or third-party physicians staffing agency rather than the facility. The facility can deflect reporting responsibly to the third party, which is not

obligated to report the offense to the state. That means the physician may then leave the health system only to repeat the behavior at another health system. That's really not ideal. There are other regulatory gaps as well. I think one of the things we need to think about is like how do we communicate regulatory gaps to the Department of Health? Do you want us to look at regulatory gaps? Do you want us to bring them to your attention? How do we want to look at this stuff together? The other thing I wonder about is do we have outdated regulations? Why do I have a picture of someone pruning a rose bush might be your question there, right? Well, it's because if you're at all a rose gardener. I do like roses, by the way. I learned a long time ago there's many ways to keep my wife happy. One way is to plant roses and take care of them. If you prune a rose bush, it comes back stronger and it does better, and it stays healthier. This is what you do with rose bushes. I think the same is true from regulations though. Regulations, some of them are very old. Some of the regulations weren't made for foundation of health equity. Some of the reasons why the regulation existed aren't present anymore. Some of our regulations might be getting in the way of achieving our goals. Would it be worthwhile for the department to work with you looking at this? Should we do a little bit of pruning around our regulations and see what we have to take away? I think we're really good at adding new regulations. During the pandemic, that was necessary. Since then, we've been a lot that we've added. I think one of the things we need to think about is like what is the old that we can take away? I think one of the things we have to think about is there's some things that are really simple and non-controversial. Is there a way to move that through the system quicker, right? I was thinking, for example, like when we changed credentialing in a hospital for three years to match what joint commission does. There really wasn't a lot of pushbacks on that. It takes a long time. It's a year, right? You can actually have a baby elephant by the time we get a regulation done most of the time, right? That just is what it is. It makes you wonder. Can we speed up some of this? I do think it'd be nice to know, like, what do you want us to do in this space? Are there regulations we should prune a little bit? Here's one example of an outdated regulation that's no longer relevant. Really, this isn't done in hospitals anymore. 405.9, every patient shall have a complete history and physical exam performed by an appropriately credentialed practitioner. Such examinations include a screening, urine cytology, married women 21 years of age or older so a pap smear, unless such test is medically contraindicated or has been performed in the previous three years. You know, in the world of patient centered medical home trying to improve primary care, I think we have to ask yourself what was the intention then? Is the intention present now? There are other regulations I wonder about. One is the twelve-week rule. I'm not sure what we're doing there. I'm not sure if the twelve-week rule for physicians in medical school where they're going. There are other things I just think we should be thinking about together about where do we want to go in the future? Part of when you take a regulation and try to prune it you have the conversation. People have feelings about regulation. That's important. Let's get the feelings out. Talk about it. How can we make it more up to date and be more reflecting what's really going on? I want to talk a little bit about data. I'm really glad Dr. Rosenberg's coming this afternoon to talk about how we interact with data. Data is critically important. You know, I often say data diffuses dissension. I live in that world where data is objective. It helps us make good decisions. I really often believe if we all have the same information we're more likely to make more effective decisions here. We use data all the time for public health priorities, informing our decisions around the department, aligned requirements and data standards. We're integrating data. We're doing a lot in the department to modernize data. It might surprise you to know we have 435 different databases in the department. It might even surprise you to know that we have computer programs that include Fortran. For those of you who don't know what the computer language Fortran is. When I was in college in the late 80's, that was a new language that people were really excited about. We're modernizing some of these programs, so we aren't still using Fortran and COBOL.

Thankfully, we don't have anything in Basic anymore. I think that's sort of an interesting thing, which is that it's really important to modernize our data, optimize our systems, talking to each other, and really do we can map our data and use it effectively. We're a big agency. We have a lot of big data. It's just a matter of leveraging that. I know you're having a conversation that afternoon about character and competence. I think that's really important. It's really one of the criteria we use here. When we talk about that, we're really talking about review of approval for new operators under public health law, public health and public health planning is the final approving authority here. It's based on experience, past performance of proposed owners and operators. Are there records of violations, if any? For hospitals, nursing homes and diagnostic and treatment centers a substantially consistent high level of care. You'll have a whole hour on this topic, but I think it's really important to have a deep understanding of it. I'm just going to touch on the 1115 waiver a little bit. I think it's important to know that this was a lot of work that occurred in the department, in our Office of Health Insurance programs. A lot to negotiate with the center for Medicaid Medicare Services for over a year to get this highly nuanced to $7.5 billion agreement. I just want to underscore when we're talking about the 1115 waiver the word waiver is the operative word there. If it's a waiver, you what are you being waived from? Waiver means that the center for Medicaid and Medicare Services said you can do innovative projects. You can do things we normally don't pay for in Medicaid. You can do some of these new things with our blessing, agreement and investment. We're going to measure how things go. It's a waiver. It's a waiver from existing rules to try something innovative and new. One of the things that you hear about is global budget initiative, improving health equity, social care networks I'll talk a little bit more about. There's some workforce investment that we have in this, career pathways training and invest in behavioral and social care services, nutritional housing support. A lot of interest on this 1115 waiver. There is money going to rooms where we take care of people, but most of the money is going to spaces outside of those exam rooms, operating rooms, emergency rooms. Most of the money is going into other places that we needed to make investment in. Workforce is something I think we all talk a lot about. I don't know that we understand how critical this is, though. When I think of things that are concerning me for our aging demographic, which I am now part of. As we get older we're going to do health care more and more. We simply don't have the health care workers. We just don't. I think it's really important to say that we're doing what we can, but we really need to have partnership with the legislature on some of our scope of practice initiatives. I mean, I've talked to you the last few times I met with you about simple things like, let's not be the only state that won't let a medical assistant give a vaccine. We need to do with oral health. In other words, we're a state of 600 million teeth. We need to have more dental hygienist, dental hygienists who can do more. We need to look at dental therapists. We need to look at how we deliver anesthesia in New York. There are other ways other states have done this. We need to look at what medication aides are doing in nursing homes. None of this stuff is Avant Garde or groundbreaking. Its stuff other states have already done. Our 1115 waiver workforce investment, which is in total $694 million will have very limited impact if we aren't partnering with the legislature. We put forward this year, I think, very simple, straightforward things that I think would just help us move in that direction. Career pathways training, the most substantive investment, trying to engage people early in their life about a career in health care. By the way, health care is a great way to make a living. You go to bed at night with the sense of I was helping other people. You get a job with health insurance. It's satisfying. It's interesting. Because it's perpetual and always changing if you're bored that's your own fault. Because health care is always changing. It's a really wonderful way to engage in a career. In case you are curious would I do it all over again? Absolutely. I love what I do for a living, right? We're doing a lot with workforce investment organizations. Again, foundational concept of health equity. How do we get

more people into health care and more people who look like the patients are taken care of. There is money for student loan repayment. You know, $48 million is added to the other investments we have. One of the things we have to acknowledge is are we pricing ourselves out of existence in health care? It is phenomenally expensive right now to become a physician. You know, if you think about when I left medical school in 1990, I owed $40,000. Thank you, U.S Navy, for paying for three years of medical school. $40,000 wasn't a lot of money in 1990. It is very common now for people in medical school on ten times that amount or more. That just really shapes your future if you owe that much money. Loan repayment would go so far, but there are novel strategies being discussed about how do we make medical school three years instead of four years? How do we make it more affordable? How do we make it more accessible? The department some diversity in medicine investment, which I'm very pleased with, but I think we need to look at other concepts of where we can go with this. The social care networks. Really a nice piece to the 1115 waiver. You know, really looking at who are the populations who really could benefit the most from social care networks. Some people are high utilization including those who aren't stably housed, individuals who have serious chronic conditions, people with substance use disorder, mental illness often co-occurring. Anybody who's pregnant, anybody who's a child under age 6. You know, in 2025, we expect to be offering continuous eligibility for anybody under 6 years of age. Once eligible for Medicaid, all the way eligible through your 6 years of life. Anyone under 18 with chronic conditions, foster care, really concepts about improving housing supports, nutrition, health related social needs, transportation. A lot of what we would just call social determinants of health. I did want to talk a little bit about the essential plan. I think it's important that we have a little bit of a distinction between the 1115 waiver and the 1332 waiver. Again, really abstract notions, right? 1115/1332. These are just numbers, right? They're waivers. When you think about the essential plan just to have a frame of reference on that. What the essential planner refers to is the Affordable Care Act just so we're on the same page. The Affordable Care Act is also referred to as Obamacare. I don't refer to it as that because I refer to it as the name of the law, the Affordable Care Act. It's really a wonderful thing that New York opted into. We've been very successful in New York with this. It's roughly a $13 billion program, but it's a wonderful tool that we use to offer health insurance to a wide variety of people. April 1st, we expanded eligibility to anyone up to 250% of federal poverty limit. If you're a single individual that's up to $38,000 a year. You can have decent health insurance at no cost to you. It's helping an additional 100,000 New Yorkers. Subsidies to consumers 400% of federal poverty line are expected in January of 25. And by subsidies what I mean is that if you don't have health insurance through your employer, as long as your income is below 400% of federal poverty line we'll be able to help subsidize your premium so you're not paying as much. This is really a nice move and helping health insurance be as accessible to as many people as I legally can right now. I think it's important to see what we're doing in 1332. When you have good health insurance it really helps everybody, right? Not only can the person access health care, which is really what matters the most, but it's also nice for people who are health care workers in hospitals to be able to provide the care and get compensated for it. I wanted to make some closing thoughts really quickly. I thank you for coming again today. I think it's really important we work together. I hope you view the department as a partner with you. I want to make it really an important distinction between partners and stakeholders. You know, they're not the same, right? Partners worked together through thick and thin. We may not always agree, but we're still working together. Stakeholders, they have a vested interest. If they don't get the way, they sometimes do other things, but they're stakeholders. They're both important. I'm hoping you view the department as a partner and you want to work with us, because I think it's really important that we do what we do together. I'm going to close with this concept just reminding you what health is. I think it's always important to remember

what the assignment in front of us is. The assignment in front of us is to help everybody in New York achieve a state of optimal physical, mental, and social well-being. That's what I'm trying to do with everything I do. I think it's really underpinning our mission here at the Public Health and Health Planning Council as well. I'm going to stop my time there, see if there's any questions or any thoughts.

Commissioner McDonald Back to you, Jeff.

Mr. Kraut Commissioner, thank you so much. I think that's just a great way to set the table for some of our conversations. You essentially hear the encouragement of us of the work we need to do that we've been doing, and we need to continue to do.

Mr. Kraut Are there any questions for the Commissioner? I know that's one of our more favorite times when we're together on anything that he discussed or any point?

Mr. Kraut Dr. Kalkut.

Dr. Kalkut Thank you for the presentation. There's really a lot of real substance in there. It's fantastic. The global health initiative in the waiver I think has real promise to make changes in the health system, particularly in Brooklyn that are sustainable. To me, one of the best things in the waiver, I realize it is a trial in some ways, but it does align incentives in a very important way.

Mr. Kraut Just as a follow up to that. Do you know when there's going to be details?

Dr. Kalkut Conceptually, I think it's a terrific idea.

Commissioner McDonald I want to make sure we have a common understanding about global budgeting. Global budgeting the way that it's currently been described is something called the AHEAD Model. AHEAD is an acronym. It stands for all payer health equity approaches and development. The simplest way of framing it is you'd say to a hospital all the players are going to give you all their money. Here it is. They'll be following a trend. A hospital you have all that money to spend. There's no incentive then for the hospital to do anything other what is right and good for the population. That's the overarching concept is just to do what is right and good for the population. You're just as equally incentivized to screen everybody with a screening colonoscopy as you are to do bypass surgery, also to do well-child exams and well checkups and get everybody's mammograms done. Because those are the things that really matter, right? Like when I think about health screening in particular, it really would help us off if we found the cancers early so people could have better outcomes. You asked when, and I don't have an exact time, but in the next fiscal year it'll be clearer what that rollout will look like, because hospitals need time to opt into that and need time to plan for that. I'm glad you're excited about it. I think it's overall going to help a lot of the hospitals in Downstate in particular. One of the things I want to distinguish is the all-payer health equity approach and development is really probably going to help the Downstate hospitals much more. Upstate weren't left out, but they have something different called Making Care Primarily available to them. New York State is the only state that was able to opt into both of those through Center for Medicaid/Medicare Services. I think there's something for everybody when it comes to how do we improve and stabilize hospitals. Having said that, there is money in this particular 1115 waiver that will help stabilize some of our financial distress hospitals. There's also money in the budget as well. We're really recognizing that it is important to stabilize our hospitals. I think one of the comments I would share with you though is that I don't think we should only look at

stabilizing hospitals and how do we give hospitals more money? I think we need to find how do we make hospitals reduce costs? There are things we can do that reduce hospitals costs. The New York State Insurance Fund with the Governor announced yesterday an interesting little project. If you do some energy things will help lower your premium for workers compensation by 5%. It's a small thing, but this is type of thing where if you can help a hospital reduce a cost and worker's compensation that helps. There's a lot of work we can do together to help hospitals reduce costs and the staff is thinking about things we can do with that as well. It's a long answer to an honest question.

Dr. Kalkut Thank you.

Mr. Kraut Any other questions for the Commissioner?

Mr. Kraut Yes, Dr. Boufford.

Dr. Boufford Thanks very much, Commissioner. I mean, our conversations for reasons of our responsibilities tend to be very provider dominated. I wondered if you could talk a little bit about the department's engagement with health plans, which obviously have incentives to keep people well and to promote prevention, potentially insurers as well. I know some of the scale of insurance makes that a little bit harder to focus on, but if you could talk about that a little bit in the context, maybe of Medicare, but also of other insurance systems.

Commissioner McDonald You know, let me give you a couple examples from the Essential Plan, because one of the things we're really trying to do in the plan is how do you take a preventive service and make it at no cost for everyone in the Essential Plan or qualified health plans? One of the differences I want to talk about an Essential Plan is a little bit different than the qualified health plan. They're both administered to the New York State of Health, but the qualified health plans are for people who buy insurance from us through the marketplace. One of the things we've done is really eliminate cost sharing for certain things even in qualified health plans, maternal care, postpartum care are just a few examples that come to mind. We're doing similar things with chronic disease reducing cost sharing as well. One of the things we're trying to do, and I think this is one of the things interesting about the health department. I don't know how many people know this. There are only seven health departments in the country where Medicaid is part of the health department. I don't know of another one that has the equivalent of the Affordable Care Act in their health department. We're different. That's part of why our budget is so big. One of the things it affords us is a chance to align ourselves around the same goals. It's a real unique thing that we can do in New York that other states maybe don't have as many opportunities to do. It'll be really up to us to see if we can leverage that for its best. I think what our focus is looking on is how do we get insurance for people; how do we do cost sharing? You know, when you look at out-of-pocket expenses for people, for health care in particular, one of the things that you see when you increase out-of-pocket costs for health care for anyone. It becomes an insurmountable barrier to acquiring the health care if it's not perceived as emergent or urgent. For something that looks like a screening test, a mammogram, for example, or other carriers it's really important to remove as many barriers as possible. That's our strategic direction in that area.

Mr. Kraut Thank you.

Mr. Kraut Commissioner, thank you so much. Really, I just want to point out the Commissioner, you know, the legislators are still in session. For the Commissioner to be

able to spend a day and a half with us is a major opportunity. We really appreciate your presence here and your involvement and your leadership frankly, that made today happen.

Mr. Kraut Before I go on and introduce the next section, we're having trouble controlling the temperature in the room. I see people shivering.

(Laughing)

Mr. Kraut Very observant.

(Laughing)

Mr. Kraut Could you try to modify? It's the blowers that I think are creating. We'll turn it off till it gets warm. We'll turn it back on and then we'll turn it off. We'll do our best to keep you in some temperature zone here.

Mr. Kraut The next topic, I think we're all very excited to engage in this conversation. Several years ago... Frankly, almost a decade, we had the opportunity to review and approve a couple of projects that created on a frankly different scale the satellite and off campus emergency departments. These departments, when they've gotten approved, we had a requirement there for them to file annual reports and then for the department to come back and essentially after it's opened a couple of years to essentially come back to the council and let's discuss what we approved and what the benefits were and what are the challenges. They'll tell the stories of their history. I won't go into that. This is a long-awaited presentation. The way we're going to start is I'm going to ask Dr. Shulman to describe the regulatory framework in which these entities operate in. We have representatives, she'll introduce the speakers, but we have representatives from the Northwell, Lenox Hill, Greenwich Village facility, the NYU Langone, Cobble Hill facility. In Upstate, we have from the University of Vermont Health Network, the Elizabeth Town Community Hospital facility. We'll see kind of three different examples in three different locations under three different set of similar circumstances how those evolve.

Mr. Kraut Dr. Shulman, I'll turn it over to you.

Dr. Shulman Good morning, everyone. My name is Stephanie Shulman. I'm the Director of the Department's Division of Hospitals and Diagnostic and Treatment Centers. I'd like to talk to you this morning about the development of satellite off campus emergency departments. Let's talk first about what are these. These are hospital sponsored off campus emergency departments. They are operated by a licensed Article 28 General Hospital that is physically located at a different site then these off-campus emergency departments. What is the history and the reasoning for why the department implemented this type of emergency department? They increased the availability of emergency care in more convenient and readily accessible settings. They relieve overcrowding of hospital-based emergency departments. Those are the general hospitals. They operate with faster throughput, resulting in reduced patient wait times and increased patient satisfaction. Dr. McDonald did talk about wait time just a little bit earlier in his presentation. They are more economical and efficient than constructing new hospitals. They fill health care voids in underserved regions. Regarding New York State law, New York State allowed for the operation of hospitals sponsored off campus emergency departments and relied on the Centers for Medicare and Medicaid Services and existing regulations to govern ownership and operation. The Regulatory Modernization Initiative in 2017 addressed this further. What was the Regulatory Modernization Initiative Workgroup? It was originally intended to

provide emergency medical services in rural communities where there was no acute care hospital, no general hospital that was licensed to provide care for patients, and the distance to travel to an emergency room from their community was too great. Emergency off campus emergency departments have now expanded into urban and suburban areas where there's need. The Regulatory Modernization Initiative Workgroup recommendations are that New York State should continue to allow only those off-campus emergency departments affiliated with a hospital or a hospital system. It is not necessary to create a new need methodology, demonstrate need for services, value to the community, impact on surrounding emergency departments, and allow flexibility to account for unique local factors in the decision-making process. In terms of regulatory requirements, they are similar. These off-campus emergency departments similar in terms of regulatory requirements to any other emergency department. I realize the print is a bit small here, but this is just to give you an idea of how comparable they are to emergency departments that are located in general hospitals. Governing body is applicable. Administration, medical staff, nursing services, quality assurance programs, patient rights, adverse event reporting, medical records, infection control, surgical services, anesthesia services, respiratory care, radiologic and nuclear medicine, laboratory services, pharmaceutical services, emergency services. And then, of course, they must comply with Public Health Law 2805T, which are the clinical staffing requirements. On this slide, we're showing to you New York State locations for off-campus emergency departments; Montefiore Medical Center, Montefiore Westchester Square, URMC Strong West, Adirondack Medical Center, Lake Placid is a closed location, NYU Langone Hospital, the Joseph S. And Diane H. Steinberg Ambulatory Care Center, South Nassau Community Hospital Off Campus Emergency Department, Lenox Hill, Greenwich Village, Fox Memorial, Tarrytown Campus, the University of Vermont Network, Elizabethtown Community Hospital, Moses Ludington, Health, Bay Ridge Emergency Department, DeGraff Medical Park, Stony Brook, Southampton. These are operating off campus emergency departments. They offer tremendous value to the community. They provide that opportunity for patients to receive care in a setting that can give them what they need. If they need to be transferred they already have a relationship because they are operated by the licensed general hospital, where they can obtain additional care if those services are needed. As you know, it was described earlier in the presentation there will be representatives and guest speakers from some of the hospital systems that are operating off campus emergency departments so that we can have additional discussion related to this very valuable topic.

Mr. Kraut Before we go to our presenters, is there any questions about the regulatory framework that these entities operate under and that they'll give examples of the interpretation?

Mr. Kraut Dr. Berliner.

Dr. Berliner Two questions, please. Why was the place that closed, the Adirondack place closed? We also have some hospitals that closed their emergency rooms for particular periods of time like in Lake Placid. Can you talk a little bit about that?

Dr. Shulman Regarding the Lake Placid closure, the volume of people going into that emergency room were very low. The acuteness of the patients going into that emergency room was more primary care than the requirement of urgent care or emergency care. That community has closed their emergency room. The closest emergency room to them is not that far away. There's another emergency room near to them. What Adirondack Health did was they also because what the patients they were primarily seeing there were primary

care patients. They have expanded their hours for walk in primary care to be able to address that.

Mr. Kraut Stephanie, my recollection was we also not only approved the establishment of that, but they also came back to us as an interim move. We, for the first-time established part time. In order to try to keep it viable we allowed it to not work 24/7, right? I think that was an interim move, but that subsequently they came in for closure. It did show flexibility on our part in using this model to adjust to the needs of that community.

Dr. Shulman What is occurring in New York State if you look at our census and you look at the demographics, some of the smaller communities are shrinking. Services still need to be available in those communities. Dr. McDonald did speak about health equity and the department's continual working on to ensure that patients have the ability to obtain care. We're always looking at that in everything that we do. We take it very seriously that patients can continue to receive care.

Mr. Kraut Thank you.

Mr. Kraut Yes, Dr. Soffel.

Dr. Soffel Hi. Question. Do these regulations also encompass psychiatric emergency department services or is this limited to physical health?

Dr. Shulman What I'm speaking about today, off campus emergency departments are not psychiatric CPEP facilities.

Mr. Kraut You might want to ask our presenters what happens if.

Mr. Kraut Ms. Monroe.

Ms. Monroe This is a great improvement in accessing care, particularly in rural areas. Yet when I look at these locations, I don't see that many rural areas have capitalized on this opportunity. There seem to be more of them in urban and suburban areas. My question is, what are the barriers that are keeping some of these hospital systems that are untapped in underserved communities from creating something like this?

Dr. Shulman the hospitals... You have critical care hospitals. CMS has a new version of emergency rural hospitals. Reimbursement rates from CMS provide the hospitals with a variety of different operational abilities to be able to provide those services to the community. Many of your rural areas are critical access hospitals. There are some rural areas that are considering being rural emergency room hospitals. Many of the rural communities are still operating as a critical access hospital. CMS gives them increasing reimbursement for that. It also provides those very limited. They have to have under twenty-five beds, very limited, I believe it's under twenty-five very limited inpatient beds, which offer value to that community so that they don't need to be transported for very general things. Your critical access hospitals have limitations in terms of what type of care they can provide there.

Mr. Kraut Is it on?

Dr. Kalkut The facilities I'm familiar with Downstate are all at sites where there was a closed hospital. Are there any of the eleven, I think, that are that are freestanding

emergency departments established de novo without relate related to a closure of a hospital in a site where there are long distances, for instance to an emergency department, perhaps in the rural area? Are these all related to closures?

Dr. Shulman in looking at these just briefly, and I'd have to do more research to fully answer your question is most of them were hospitals that were fully operational at one point, but now continue to service that community by providing that easily accessible emergent care in that off campus emergency department.

Mr. Kraut I think that's a good jumping off point to having our presenters talk a little about it now. The way the agenda was constructed and I'm frankly open to pivoting is we were going to have the three presenters make their presentations about fifteen minutes or so each. We were going to have questions and discussions. Given the tenor and the give and take here if you feel that you'd like to ask questions immediately and not wait for the other one. I'll take the temperature. We'll pause if you think that's okay or not. I just thought it might be efficient to hear the sum total and then go back and question. If I'm wrong, we'll go with every direction you'd like to go with. Our first presenter is from Northwell, Lenox Hill, Greenwich Village, Tracy Feiertag, who's the Deputy Executive Director of the facility, and Dr. Tucker Woods, who's Chair of the Emergency Department and the Associate Medical Director.

Ms. Feiertag Thank you so much for having us here, Commissioner. I agree completely with you about the honor it is to work in health care. I wake up every day and can't wait to do my part. That definitely resonated with me. Thank you so much for having us here to share our story about Lenox Health Greenwich Village. My name is Tracy Feiertag. I'm the Deputy Executive Director. I'm here with Dr. Tucker Woods. We will share our story with you. We're going to talk a little bit about the origins of Lenox Health Greenwich Village and the community involvement, the community commitment, and the community interactions that we've had over the last ten years. Dr. Woods will share our current operating statistics and our operating model, and then we'll finish off with a little bit of vision for our future.

Ms. Feiertag I'll start our story by talking about our famous building. This building was constructed in 1963. It was designed by Albert Ledner. It was the Joseph Curran Building, which housed the headquarters of the Maritime Union. In 1969, it actually became a landmark building, which has left us with a lot of barriers in terms of the construction. It's such a beautiful, exciting building that we're happy to be part of that landmark community. In 1973, the building was bought by Saint Vincent's Hospital. The building name was changed the O'Toole Medical Services Building. It provided outpatient services to the Greenwich Village community for the next thirty plus years. Those services were critical to the community, as well as the services provided by the main hospital, which was across the street. Unfortunately, in the early 2000's, Saint Vincent's faced financial hardships resulting in a closure in 2010. At that time, the Department of Health and the state was looking at the number of inpatient beds in the state, in the city. They were looking for a health system partner who was willing to look at a new model of care. We partnered with the state with our local elected officials to figure out what does that new model of care look like? It turns out that 70% of the folks that were living in the Greenwich Village community were actually not getting their routine primary care through Saint Vincent's. They were going to other systems. Only 30% of the community was actually accessing those services at Saint Vincent's. What they all were getting, though, at Saint Vincent's was emergency care. That really guided the decisions in opening the first freestanding emergency department in Manhattan. We opened that in 2014. A couple of pictures. I have a bunch of pictures in this presentation. This was the initial construction. We had initial financial

investment of $150 million. This next photo is what it looked like when it was complete. Again, we're celebrating our ten-year anniversary this year that we're very excited about. We opened this. This is a division of Lenox Hill Hospital. As mentioned, part of the Article 28 operating certificate for Lenox Hill. We have two licensed inpatient beds that sit within the emergency department. Understandably, the community was up in arms. They lost their hospital, and now we're saying we're going to open an Emergency Department, which for them looked a lot like an urgent care. We understood that they were upset. This is a community, Greenwich Village of Advocacy. They're used to advocating. They definitely did. We needed to figure out how we were going to handle this. How do you handle opposition? You attack it in terms of getting involved. We got very, very involved. We went to their community board meetings. We went to their community rallies. We worked closely with elected officials, but they were still feeling like this was not going to solve their needs. We were isolated. They were concerned about transfers. There was lots of concern that we would not be able to care for the community safely with this new model of care. We invited them into the building. Even before we opened, we had open sessions where people could just walk into the building, meet us, see what we had to offer. Slowly, people started to feel a little more comfortable. It was many years of opposition. What we knew we needed to do. I just have some photos here of some of the protests. Some of this was around the closure of Saint Vincent's Hospital. This is a photo just so you could see where we're located. Part of it is that on the West side of Lower Manhattan there are no other medical services. You have to go to the East side to get to where Beth Israel is/Bellevue/ NYU. We were pretty distant from the next closest facility. This is an aerial view where you could see that white building is the top of our building. The building right across catty corner on Seventh Avenue there was the St. Vincent's hospital. In addition to engaging with the community, we knew that we really need to do a thorough needs assessment to learn who the community was and what they actually needed. We do these community assessments like most other hospital systems on a regular basis. We've continued to do this. This one is actually very recently updated. Looking at the demographics within our community to make sure that back then and moving forward we're continuing to identify the needs of the community and addressing them with added services over time. We also have engaged tremendously with many community partners. We have actually a shared wall with the center, which is the country's largest LGBTQ Center, Community Center. We do a lot of work with them. We also do a lot of work with other community partners that are helping to deliver care to underserved. We have very good relationships with the schools in this area. We also know that we can't just partner with these communities and tell them about what services we have in the building. We also need to go out and provide service to them. We do lots of screenings in the community. We make sure that constantly asking what it is they need. We do listening tours to understand is it blood pressure screening that you're looking for? Is it skin screening? We make those adjustments every time we do a listening tour and continue to have these conversations.

Ms. Feiertag I'm going to pass it off right now to Dr. Woods to tell us a little bit about the current state.

Dr. Woods Good morning, everybody. Thank you, Tracy. Tracy did a really great job describing our journey prior to opening. I'm next going to talk about what our current state is at Lenox Health, Greenwich Village. This is our facility now. We have our Emergency Department on the ground floor. We have a beautiful Imaging Center on the fourth floor. We have our Physician Partners Offices on the sixth floor. Finally, we have our Ambulatory Surgery Center on the fourth floor. There's that expression build it and they will come. This heat map highlights where our patients come from. They really come from Lower Manhattan, especially 23rd Street below. The dark red areas are where it's mostly

concentrated. It's West Village, Chelsea, Gramercy Park, East Village. It's interesting. The lighter shades show that patients really come from all over New York City, even New Jersey. We actually get patients from Brooklyn. We get patients from Queens, Northern Manhattan. We get patients from the Bronx. We don't show it on this map, but we also get patients from New Jersey from Hudson County. In terms of a historical volume in our Emergency Department, when we built the facility, we were expecting about 24,000 patients per year. We actually see more than that. This goes back to 2017 through 2023. In 2017, 18 and 19, we were seeing about 105 patients a day, 108 patients a day. When COVID came, obviously our ED volume dropped, as did other emergency departments across the nation. Slowly we're getting that volume back. Last year we were back at our pre-COVID levels. 2024 year to date, we're actually above those pre-COVID numbers. We're averaging about 110 ED visits per day. In terms of the ambulatory surgical volume, in 2018, we had a little over 550 surgical procedures. It grew in 2019 to 1,300. Obviously, during COVID 2020, we saw that dip. Came back up post COVID. We saw a big spike in 2022. That correlates to when we opened up our endoscopy suite. We opened that up in the Summer of 2022. Last year we saw we had just over 4,600 surgical procedures and endoscopy procedures. In terms of the historical imaging volume 2019 through present. In 2019, we had about 23,000 plus imaging cases. If you fast forward to 2023, we're seeing just under 38,000 imaging cases per year. I want to talk a little bit about our operating model. We basically follow the hub and spoke model that many of you are familiar with. What's our hub and what are the spokes? In one sense, you could look at the hub being Northwell itself. We're 85,000 plus employees strong. Northwell itself is sort of the primary hub, but from a Manhattan perspective, where Lenox Health, Greenwich Village is located, Lenox Hill Hospital is the hub for us. In terms of the spokes, what are the spokes? The spokes would be our facility, Manhattan Eye/Ear/Throat, our ambulatory surgery, our inventory, primary physician offices, go health urgent care centers, telemedicine, EMS. They make up the components of the spoke. One of the keys to our success as a satellite Emergency Department is our transfer center. When we do have a patient that requires admission or higher level of care or transfer, we have our centralized transfer center is really key to successfully moving our patients out. Whenever a patient requires an admission we simply call the CTC. We can even activate it on our digital app. The reason it works so well is when we do call the transfer center the very first question they ask is, is this a Tier One or Tier Two? Tier One means that patient needs to leave now. They need to leave lights and siren. If I have a patient that needs to go to the ICU, I say it's Tier One. We have this auto launch feature. As soon as I say Tier One they auto launch the ambulance and the paramedics. They will take the patient's name, date of birth, diagnosis. That crew is already on their way to my patient if I say Tier One. Another thing that I think works well is when we do have a patient that requires admission sometimes patients go like in a lot of other sites they might go ED to ED. But if they're being admitted to Lenox Hill What's nice, and I think it's more patient centered Is they will go from our Emergency Department to the actual floor at Lenox Hill Hospital. One surprise in regard to admissions while I'm on the topic is when we opened we thought patients would prefer to go to their primary health system, whether it be NYU, Mount Sinai, Cornell, because we have transfer agreements with everybody. What we found was a lot of the patients did want to stay with us after that first encounter. Just one other model that makes us work well as a satellite ED is if we're holding admitted patients and Lenox Hill Hospital, our primary hub is holding patients. Ours will actually get those beds first. Because we realized early on that we don't have an inpatient upstairs. The hospitals cannot come down to round on the patients. Consultants cannot come down. It's pretty rare that we actually have a boarding problem because our ED admitted patients take priority.

Dr. Woods My EMS slide is missing, but I can just talk about it quickly.

Dr. Woods In terms of one of the other spokes in our hub and spoke model it's definitely our EMS. They put out about forty-five to fifty ambulances per day to serve. That serves the footprint of the entire health system. Given that our site is so busy. We're the only hospital in Northwell's system that puts out about four or five directly from our site. We turn out about four or five units a day. On top of this fleet, we also have three ambulances that are part of the 911 system under contract. Another spoke and that we use frequently is leveraging innovation. Telemedicine is definitely has been a big win for our department. We currently only have two specialists that come on site to evaluate patients. Otherwise, we leverage technology. The best example I could give would be the use of the EICU. If I have a critical care patient that I'm admitting to Lenox Hill, although I don't have an intensive in the building, I can we'll in our telemedicine cart. Our ICU physician comes on within seconds when I press that tile on the Teladoc cart. We have high powered cameras so the physician can actually zoom in on the pupil. They can rotate the camera. They can look at the cardiac monitor. They can look at the pulse ox. It's pretty amazing. They will actually round on the patient hourly, place orders in the chart. We have a time to intensive the goal of sixty minutes or less. Leveraging technology has been a big win. That's just one example. We also have telepsychiatry. We have tele stroke. We have addiction medicine health coach teleservices. Just starting today actually we now offer tele pediatrics. It's been a big win for our community. Last year we actually had over 100 tele ICU consults. Anybody can activate it. It can be the nurse. It can be the PA. It can be the physician. Lastly, I just want to talk about the current ambulatory landscape. All of these ambulatory practices are highlighted on this map. This is really 36th Street and below. Traditionally, you know, ten, fifteen years ago, hospitals, bulk of their business came from the hospitals themselves all the business generated by the inpatient admissions, the revenue associated with that. Northwell has made such significant investments in our ambulatory practices and our ambulatory landscape that we're actually at the point now where in terms of Northwell's revenue as a system only 47% of the revenue comes from the hospitals themselves. Northwell felt it was critical to develop and invest in these primary care outpatient practices. 53% of our revenue actually come from outside of the hospitals from this ambulatory landscape. You have a good overall view of our current state.

Dr. Woods I'm going to pass it back to Tracy, who's going to talk about what's ahead in the future.

Ms. Feiertag Thank you.

Ms. Feiertag Also important to know, the ambulatory landscape is none of this was in existence prior to the opening of Lenox Health Greenwich Village. This is all the work that we've done to build up that primary care and specialty care services right around the Emergency Department. We talked about our past and our present, and now what does the future look like? We are very excited right now. We are actively in construction on building freestanding Cath lab in our building as well as an inpatient unit. What we did was we continued to, like I said before understanding what the needs were in the community. What we heard a lot was that, yes, we do want to stay within the Northwell system. We do want to go to Lenox Hill Hospital, but we would really prefer to stay here in our community. The new inpatient unit will only have eight beds. It will allow us to take care of some of those lower acuity med surge patients that don't necessarily need to go up to Lenox Hill or to another hospital. I just have some pictures here of the renderings. We're very excited about this. I'll just talk one little story. The other day, I was rounding in the Emergency Department. I came across a couple in their 80's. Just to see how their experience was I

said, how is your experience been? They said, well, it's always great when we come here. The wife said, my husband needs to be admitted. Every time he needs to be admitted he goes to Lenox Hill where he gets great care. I can't take the subways anymore. It cost me $30.00 to Uber there. Every day I wake up thinking, should I spend that $60.00 on Uber to Lenox Hill Hospital? He needed a low acuity inpatient admission. I thought, this is exactly the community member that we will win by having these eight inpatient beds. It really just makes us extremely thankful that we have engaged the community. The community is changing the way they feel. As evidenced by some recent newspaper articles where people are really trying to learn about who we are and what we have to offer. I'm going to just finish. We'll see if it'll work with a very quick video of some of our community members.

Video Speaker One I'm a family nurse practitioner, a community activist, and a lot of people want to know what I think of Lenox Health, Greenwich Village. Well, I was like a lot of people in the past, up until recently.

Video Speaker Two My experience at Lenox Health in Greenwich Village has always been positive. Let's face it, when people come into the emergency room, they're at their most vulnerable.

Video Speaker Three We've had enough experience to get an appreciation for the well-rounded services. It's an emergency room to an extent, but it's also a lot more.

Video Speaker Four I found that the quality of care not only met my expectations but exceeded.

Video Speaker Five I worked in health care for about twelve years. I've seen different situations in different facilities. I will say it's clean and the people are really, really thorough. Over the years it's become apparent that you can trust this place.

Ms. Feiertag Thank you.

Mr. Kraut Thank you so much.

Mr. Kraut As I said, we were going to wait, or we can ask questions. We're going to ask questions. There you.

(Laughing)

Mr. Kraut Mr. Robinson, Dr. Berliner, Scott La Rue. We'll go around the table.

Mr. Robinson Maybe this is less a question than an observation, but I think that the pattern that we just heard of one, example of one of one with the Greenwich Village site is actually what we're seeing with these freestanding ED's across the state. In different states of evolution, but it seems like we set them up as freestanding ED's with all of the requirements that the state is appropriately placing on them. I think you're seeing out of necessity almost a restoration of some inpatient capacity that needs to accompany it over time, particularly as they grow. I mean, that may be just an appropriate natural evolution of how we should be looking at these things. In other words, they're not necessarily going to be fixed in time as freestanding ED's. They're almost coming back to being micro-hospitals. I think as we think about how we're looking at these kinds of models we need to sort of be as flexible as we've been with the establishment of these freestanding ED's and

recognize that that evolution is probably doing the right thing for the communities that they're serving. It's just an observation.

Mr. Kraut Let me just go clockwise so I don't miss anybody.

Mr. Kraut Dr. Berliner then I'll go down the table.

Dr. Berliner Thank you. That was a great presentation.

Dr. Berliner I have two questions and a comment. The comment is about the Netflix documentary that started at the beginning of the pandemic, which really showed that site in a great light. In fact, I think you should have had some of the medical staff in your video. That's the comment. The questions are assuming that there is a closure of another hospital in Lower Manhattan. Are you prepared to accept a high volume of emergency room patients? The second question is if you're going from two beds and then if you add eight you'll be up to ten, right?

Ms. Feiertag We're going to use those two beds as part of the eight.

Dr. Berliner Do the new beds have to be... They have to be approved by us though, right?

Mr. Kraut They were.

Dr. Berliner They were?

Mr. Kraut Yeah.

Dr. Berliner It was done administratively?

Mr. Kraut No, it was done through the Cath lab CON.

Ms. Feiertag It's part of the Cath lab CON.

Dr. Berliner The question about the emergency room preparedness for higher volume, if you could.

Ms. Feiertag We've been looking at this. We really have no idea what's going to happen. We are prepared for whatever's going to happen. We have planning teams. We're looking at different volume triggers and ready to execute on any of those plans when things start to happen. We have over the last five or six weeks seen an increase in volume and in acuity, but we are not completely certain that it's related. We plan on doing assessments of origin for the patients to see where they're coming from. It's tough also when you look at origin, because a lot of people that receive care in Downtown Manhattan don't actually live in Downtown Manhattan. When you look at their origin it's going to be Brooklyn or Queens, Staten Island, but that's just because they're in Manhattan for work or recreation. It's a little bit tough.

Dr. Berliner Right, basically you're on the L line and so is the hospital that name should not be mentioned. It's not too difficult to imagine people just going two or three more stops to get to your place. You're also on the path line, which the other hospital does not really get that easily. One would expect that those volumes to kind of, you know, on the one hand, go up, on the other hand to remain as it is, I would think.

Dr. Woods Like Tracy said, we're not really sure what the future holds for us, but what I can tell you is when the facility was built over ten years ago they did build with expansion inside in mind. Right now, all of our ED patient care rooms are single bedded, but every room was built with double oxygen outlets, double nurse call bell buttons. We have a secondary waiting room that can be turned into a split flow model or results waiting. We did when we built it over a decade ago we did build it in the event of a patient surge for whatever reason. Like Tracy said, we're preparing for whatever the future might hold for us.

Ms. Feiertag Just to clarify, they're all already licensed beds from Lenox Hill Hospital. They're just transferring from one location to another.

Mr. Kraut Mr. LaRue, and then we'll go down the table.

Mr. La Rue Good morning. I don't know if this is for Ms. Shulman or for the speakers. I'm curious about outcome data. Is there any comparative data either on mortality rates or outcomes that compares these satellite ERs to a traditional?

Ms. Feiertag Thank you.

Ms. Feiertag I can't answer that question because that might be the Office of Patient Care and Safety that may have that outcome data, but I don't have that outcome data.

Mr. Kraut You can ask them.

Dr. Woods We're an extension of Lenox Hill Hospital. We fold into their quality department. We have all the same metrics and measures as the other hospitals. We do just as well and sometimes even better with some of these metrics. We do hold quality near and dear to our heart because it's important and it affects patient outcomes.

Mr. La Rue I'm not sure I understood. Did you say that your data from this satellite is folded into the data from Lenox Hill Hospital, or is it publicly tracked separately?

Mr. Kraut I'm answering because I was the person who planned this back in 2010. You also have to remember it's not an apples and apples comparison, particularly when you look at mortality because there are certain conditions that they did not mention and maybe the others could elaborate on this that is prohibited from bringing to them. You can't have active trauma, active birth, psychiatric, active psychiatric psychosis, maternal, somebody in the middle of a delivery. There are certain things that we would consider the high risk would be out of there. Would be out of there. I think on waiting times and other things you beat a typical ED, but it's not a fair comparison because of the acuity levels are substantively different.

Mr. Kraut Yes, Ms. Soto.

Ms. Soto My question relates more to the waiting time in your facility. You shared how the volume had increased so much since 2017. You went into a bit of detail of patients being transferred and how the initial call triages what tier there were on. What about the people who walk in? I'm just curious, again, if you're increasing volume how long are patients waiting to be seen and treated?

Dr. Woods Sure.

Dr. Woods It's something that we track very closely. It was interesting because they displayed the average ED wait times on the initial slide deck. I think I said 2.3 hours or three point something hours. I personally take the position that the waiting room is the most dangerous part of your Emergency Department. We do over staff a little bit because we think it's important to get that patient in right away and evaluated by the physician. We want really good door to doctor times, our door to provide our time. Last year, our door to provider times were on average fourteen minutes. For 2024 year to date, our door to doctor times is currently, the median time is currently nine minutes. I think it creates safety. We see a much lower, walkout rate. We have pretty good door to doctor times. I think it's important.

Mr. Kraut Dr. Soffel.

Dr. Soffel Hi. This is also a topic near and dear to my heart. Jeff Kraut and I met over the closing of Saint Vincent Hospital and the development of this emergency department.

Mr. Kraut And actually, the picture you showed with Senator Dwayne.

Dr. Soffel I'm probably standing right behind him.

Mr. Kraut She is actually right out of frame on the right side of that picture.

Dr. Soffel I'm quite sure that's true, Jeff. I was going to say that but thank you.

Dr. Soffel There was this significant gap between the time the hospital closed in 2010 and the time your facility opened in 2014. What happened to access to services in those years? Do we know anything or does the department know anything about where people went and how they got care? That's question one. Question two is do you know whether your folks now or folks who had been Saint Vincent's patients who came back? Is it a new cohort? Do you have any understanding about the transition between the hospital closure and the opening of your facility and what happened to people?

Dr. Woods In terms of where patients went, I was actually working at continuum at the time. One of our sites was Beth Israel Hospital. Greg Husk was the ED Chair,. They got clobbered initially. He said it was like a light switch. I think other facilities had a big surge as well, but a lot of them did default to Beth Israel Hospital.

Dr. Soffel Do you know whether your patients now are former Saint Vincent patients who came back? Is this a new cohort that saw something new and exciting and decided they wanted to be a part of it? Is there any way of knowing that?

Mr. Kraut Yes.

Ms. Feiertag Not really, but we do know that the community local to our area they were using Saint Vincent's Emergency Department, even if they weren't using other services. This is that same cohort, the people that live in that community. I also think that there are people probably that are continuing services now with Northwell that hadn't previously used Northwell, especially, considering that we didn't have much service in Downtown Manhattan. I would say that it's mostly the same group of people using emergency

services that use the emergency services previously. I'm not so sure about imaging or ambulatory surgery. That might be a different population.

Mr. Kraut I was trying to restrict myself not to speak, but it's very hard. We did a post closure analysis of what happened between the time they closed and the time we opened. People don't like hearing this. There's a resilience and water finds its own level with one or two exceptions. We have a white paper on this that we, frankly, should publish. 30% of the care completely disappeared. There was an overutilization here. A lot of that was transfers coming from nursing homes and the like. That just kind of disappeared out of the system. The cohort that we were most concerned about and that was concerned about access was particularly the Medicaid behavioral health. That was the one that might not have had the means to find new care. We saw those numbers as we trace them through the spark system, which was the only data base that you have. They did find other care, but that was the highest risk population. I For obvious reasons I think we continue to consider that the highest risk population.

Mr. Kraut Ms. Monroe.

Ms. Monroe Thank you.

Ms. Monroe I really enjoyed that. I've been on PHHPC for six years. I realize I still don't understand what comes to us and what doesn't. I know that we have seen at our level transfer of beds from one facility to another. We've expressed concern in some cases because it would leave a community kind of empty handed. You said that your transfer of eight beds has been approved by the department. I don't remember your facility coming to us. I'm trying to understand. Did they come for a transfer?

Mr. Kraut Yes, it was part of the CON application that we approved. First of all, two sections. When the facility was approved it was approved with two beds. The facility came to us for the cardiac Cath application it was approved to add six beds to bring it up to eight beds. That came before us. The transfer of beds were a different issue. That was actually irrelevant to the project. There is a regulation that allows health systems to transfer unused beds between its facilities.

Ms. Monroe We've sure looked at a number of those.

Mr. Kraut A lot of them come to us. Ann, I'm going to put on the list, so we come back to answer your question what comes to us and what doesn't. Because there are some that are treated administratively, some that go through limited review and some that don't.

Ms. Monroe I get that. You're telling me that when the Cath lab was approved, which was way back when these added beds were approved so we wouldn't have seen them?

Mr. Kraut No, we saw them. They were part of the application. We reviewed them and we discussed them in the project review.

Ms. Monroe And that would have been when Jeff?

Ms. Feiertag The application was submitted originally prior to COVID, and then there were a few changes, and it was resubmitted and approved in February.

Ms. Monroe Well, I apologize. I don't remember it.

Mr. Kraut I think the Commissioner is going to ask the last question, and we'll go on to the next presentation.

Dr. McDonald Thanks, Jeff.

Dr. McDonald Thank you both for your presentation. I thank you, Dr. Shulman, as well. I really appreciate all of you. I was just noticing the centralized transfer center you have. That seems really sophisticated. It seems really critical to your success. I don't know if other freestanding emergency departments have that or something like that. We can ask Stephanie that. Did that start before? Was that an infrastructure that already existed? Because it seems like that's really critical for your success and to have optimal outcomes. Can you talk a little about that? Maybe Stephanie can answer later. Is that something we require?

Ms. Feiertag I'll let Dr. Woods talk about the Center for Emergency Services, which is an already established entity of Northwell. That's amazing. I's incredible the amount of ambulances that they have managing throughout all of Northwell system; out on Long Island, in Manhattan, Queens, in Brooklyn. Already existing, but Dr. Woods can tell you a little bit more.

Dr. Woods They are so instrumental. We really could not do it without them. It's a well-oiled machine. They have the largest hospital-based EMS fleet in the Northeast part of the country. We recently visited them a couple of months ago. You can see it in the movie Netflix Emergency NYC that you referenced earlier. It's almost like something out of NASA. They use a lot of data. They have really sophisticated programs. I don't want to say secret sauce. They are so supportive of us. It's critical. Working in previously at a full-service hospital, when I admit a patient now working at Lennox Health, Greenwich Village, when I admit a patient, our admissions actually get beds quicker than when I worked in a full-service hospital. They function really, really well. We have a very, very close relationship with them. It's pretty miraculous. Pretty amazing.

Dr. McDonald The Centralized Transfer Center existed before you created the freestanding emergency department? Stephanie, is that a requirement? How do we make sure when we do a freestanding emergency department that if patients need to go to an inpatient facility this is handled appropriately? Is there any existing requirement for that?

Ms. Feiertag We require transfer agreements. That's part of the review process that gets done when an off-campus emergency department submits their application. We look at those kinds of things very carefully. As was described earlier they have a very specific purpose. Certainly, under regulations you cannot turn a patient away when they come in your door. These off-campus emergency departments have very stringent requirements for how to go about first assessing the patient, stabilizing the patient, then sending the patient through that transfer agreement with another hospital. This is one of the values of having this be an off-campus emergency department. Because they already have that well defined relationship with the hospital that operates them. All of this works together to ensure that the patients receive the care they need on the front end to be stabilized enough to be transferred out. This tends to work very efficiently. I need to emphasize again that the purpose of an off-campus ED. You know, my colleague next to me works in the Bureau of EMS. These campuses, these off campus EDs are handling different patients. Certainly, they have to accept a walk in. In terms of the EMS traffic that's coming into them the patients are limited about what's coming in. Dr. McDonald, to answer your

question it's all about the volume that's coming in from EMS. Certainly, you can't change or walk in volume, but you can handle that EMS traffic to make sure that the patients who can't be handled by an off campus ED, they need a surgical suture, or they need some type of intervention that can't be performed there are on the front end they don't come, but it's the transfer agreement on the back end that becomes really important when that patient comes in there. This is very comparable to how a critical access hospital works as well.

Mr. Kraut I'd like now to turn, to our next presenter, which is Dr. Nancy Conroy who is the Chief of Service of the NYU Langone Health, Cobble Hill ED and Amy Horrocks, who's the Vice President of Hospital Operations. Similar to the Lennox, Greenwich Village, this was born out of a hospital closure. We'll leave it up to them to share their story.

Ms. Horrocks Good morning. Thank you very much for inviting us to present today about our off campus at Cobble Hill. I'm Amy Horrocks, Vice President for Hospital Operations. I've been involved with emergency services at NYU Langone Health for about fifteen years now, and I've been involved with the Cobble Hill ED since we began planning for it about ten years ago. Joining me is Dr. Nancy Conroy. She's our Chief of Service at the Cobble Hill ED.

Ms. Horrocks Next slide.

Ms. Horrocks This is our agenda. I'll start off by talking about the evolution of the Cobble Hill ED. You'll see a lot of the same themes that you heard from the Greenwich Village ED. Dr. Conroy will talk more about our care delivery models, the clinical workflows and our quality metrics.

Ms. Horrocks Next slide.

Ms. Horrocks This is our history. It starts out the Long Island College Hospital. It was in the community since the mid 1800's. They started closing services in the late 2000's. Many of you will remember this, but the community, elected officials and hospital employees rallied to save to prevent the closure, went through a lawsuit process, and the legal settlement provided for a freestanding emergency department with no intensive care unit. SUNY, who owned the facility ended up selling it to Fortis Development back in 2014, which is when NYU Langone Health became involved. At that time, we partnered to provide an off-campus ED on the site of the ED.

Ms. Horrocks Next slide.

Ms. Horrocks Turning to our strategic vision at NYU Langone Health at the time. We wanted to increase our presence in Brooklyn since we found that many of our patients were traveling from Brooklyn to Manhattan for their care. Another strategic priority was to focus on ambulatory services growth. When we established the off-campus ED at the former site this helped us to achieve both of those priorities while also we were able to maintain the continuity of emergency services for the Cobble Hill community. In addition to the ED, we plan to build a new ambulatory care center on the site so then we could provide other medical services to the community.

Ms. Horrocks Next slide.

Ms. Horrocks This is our footprint as of last month. It shows that we have over 300 locations. It's kind of hard to see because it's very small. The Cobble Hill ED, where it's located in Brooklyn is very central to our main primary service areas in Manhattan, Brooklyn and Queens. When we first opened our ED it was supposed to be in a temporary location in the former ED site. Temporary turned into about nine years. It was a seamless transition. It was the ED one day and then it was the NYU Cobble Hill ED the next. These are some photos of the exterior of the Cobble Hill ED when we opened and also the interior. Anyone who worked at the ED probably finds this very familiar. I listed the services that we had available at that site. We operated out of that first location, as I said, for about nine years. Finally, on April 1st of last year, opened our new facility, the Steinberg Ambulatory Care Center on the same block at the site, but facing Atlantic this time. We moved from the old ED to the new ED just up the block. We did that transition in one night. Again, it was another seamless transition of care. You can see what the facility looked like back in 2017 before we started demolition. This is a photo of what it looked like when we opened a year ago. We just had our one-year anniversary in the new facility. This is a stacking diagram of what the new facility looks like. The Steinberg Ambulatory Care Center. The ED occupies the first floor. We have the entire first floor for the ED. On the upper floors, we have ambulatory surgery, endoscopy, physician practices and infusion center. We also have radiology, pharmacy and labs. This is the floor plan of the new ED at the Steinberg facility. It's very hard to make out what's here from this plan. It's important to note that we increased our overall square footage by 40%. We doubled our bay count. We increased our isolation capacity from one to eleven rooms, and we also built two licensed beds in this new ED.

Ms. Horrocks I'll turn it over to Dr. Conroy and she'll talk a little bit more in detail about the new Cobble Hill ED.

Dr. Conroy Thank you.

Dr. Conroy Hi. I'm Nancy Conroy. I am the Chief of Service for the Emergency Department at Steinberg. I've actually been working clinically at this facility since January of 2015, and became Chief there back in 2021. I've been on this long journey, which has been very exciting. We function essentially the same as a hospital-based emergency department. We are an Article 28 space. We're open 24 hours a day, 7 days a week. We provide emergency services for both adult and pediatric patients. With the opening of our new license rooms, these 24 hour stay rooms, we are now receiving of critical adult patients through the 911 system. We are staffed by all board-certified emergency physicians from our Ronald Perlman Department of Emergency Medicine. And of course, we are subject to law.

Dr. Conroy Next slide, please.

Dr. Conroy We transfer from our location over 500 patients every month to our nearby locations at Manhattan and Brooklyn with the majority of our transfers going to the NYU Brooklyn campus. About 37% of our ED-to-ED transfers are subsequently discharged. That's because most of these patients are being transferred for an in-person subspecialty evaluation and consultation that is needed as part of their emergency visit. You can see approximately 13% of our total patient visits for fiscal year 2024 to date required and enter facility transfer. This included both consultations and admissions.

Dr. Conroy Next slide, please.

Dr. Conroy We have an agreement in place with Senior Care Emergency Medical Services who basically manage all of our transports through our NYU system. For the Steinberg Emergency Department, we have an ALS staff ambulance that's on site 24/7 for critical and emergent transfers. For any non-critical or routine transfers for patients who are going for consultation or to be admitted we have backup of an ALS unit if that is required that will respond within twenty-five minutes and a BLS unit will respond within forty-five minutes. Senior care is also partnered with our pediatric and neonatal transport team to facilitate transfers of critical pediatric patients. Additionally, we do utilize our Internal Comprehensive Transfer Center at NYU to facilitate transfers of critical patients, especially those who require ICU level of care, stem patients and we have a couple of new workflows since opening the new facility that include precipitous delivery in the emergency department.

Dr. Conroy Next slide, please.

Dr. Conroy Here's some of our performance indicators. I want to just start out on the bottom right graph there to highlight that with the exception of the two years during the pandemic we've seen our volume growing year over year since fiscal year 2015. We moved into the new Steinberg department, as Amy mentioned, on April 1st of 2023. We saw an increase in our volume of approximately 20% for that last fiscal year. For fiscal year 2024, we're projected to see over 46,000 patients, which would be an additional growth of almost 20%. I'm going to highlight some of our key performance indicators metrics. We've talked a little bit about mean arrival to provider times. We are actually happy to report that we're able to maintain in arrival to provider time of just under ten minutes. Ten minutes is our goal. We continue to hit that. Our treat and release patient length of stay hovers just under the three-hour time mark. Our left without being seen rate is less than 1%. There are some other metrics. We average currently volume for fiscal year 2024 of about 128 patients per day. About 20% of those are ambulance arrivals.

Dr. Conroy Next slide, please.

Dr. Conroy Looking at some of our quality metrics for the current fiscal year to date. You can see our target goals in the center column. I'm very happy to report that we are currently exceeding these goals in all areas. I will call out that our total of cases where the semi and stroke patients is low. That's because it does not include cases that were called on arrival and then subsequently de-escalated or excluded from reporting upon final review. Despite this, for the same period last fiscal year, these numbers are actually reflecting an increase in stroke and stem patients either going straight to Cath lab or receiving T and K on site, which reflects an increase in our critical patients that we started to see in the new facility.

Dr. Conroy Next slide, please.

Dr. Conroy We're always looking for ways to improve patient care through the use of technology and innovation. Some of the ways we do that are highlighted here. We do have one medical record system that is used across all of our NYU sites. NYU functions basically as one system, one hospital. Everyone has access to the same medical record for each patient in real time. Our imaging for the Steinberg site is reviewed and read remotely by our radiology and radiology attendings, who also cover the NYU Langone campus in Manhattan. We have some telemedicine workflows in place for certain patients, which I'm going to touch on a little bit more in detail momentarily. As mentioned earlier, we have about 37% of patients who are transferred ED to ED and then discharge because

they're sent for a subspecialty consultation in person. One of our primary goals, now that we've settled into the new location is to expand these telemedicine workflows to provide additional virtual consultation for additional specialty services so that we can decrease these number of transfers who can subsequently be discharged and combat the lack of onsite consultants.

Dr. Conroy Next slide, please.

Dr. Conroy This is our tele stroke workflow, which has actually been in place since we started this emergency department back in the former location back in 2014. When a patient arrives with symptoms concerning for a stroke, we activate a stroke code essentially the same way we would at any of our main campuses. The patient is immediately taken to CAT scan while the ED physician gets on a phone call with our NYU Brooklyn stroke attending to discuss the case. After they discuss the case, and the initial imaging is completed and reviewed by our neuro radiologist who sits in Manhattan the stroke attending will call into one of our telemedicine cards and have a face-to-face evaluation with the patient and determine the need for T and K. If we determine that the patient does meet criteria for T and K, we will then administer on site and help expedite the transfer of this patient to the NYU Brooklyn campus for continued care by our stroke team.

Dr. Conroy Next slide, please.

Dr. Conroy We also have a workflow that's been in place for many years, actually going back to pre-pandemic pre-2019. For patients that we suspect are low risk and potentially discharge from the emergency department as well as being capable of interacting virtually with a consulting physician. We will call our Brooklyn ED psychiatrist, discuss the case with them, and then they'll call in again to our telemedicine cart, perform a virtual face to face evaluation, and determine if the patient requires admission, in which case we'll transfer them to the Brooklyn campus for admission, or if they're stable for discharge. They'll help coordinate the discharge process and follow up for these patients. The data showing here is off of a dashboard that we developed a few years back. We've seen that approximately 74% of our patients were able to be discharged from our Steinberg facility after a consult was completed. We think we do have room to grow in this area. We're looking forward to working with our psychiatric colleagues on this.

Dr. Conroy Next slide.

Dr. Conroy We're always reviewing comments and patient reactions and looking for opportunities to engage with our local community. You can see here at the top our scores for fiscal year to date, which for overall assessment of the ED is at 90.6 and overall doctor performance is 89.8, both of which are just over our target goals. We're really happy for that. You can also see how we compare to similar facilities, both nationally and within New York State. We are above both of those as well. This also shows some of the comments that we like to try to jot down and take from patients, both in their written feedback to us as well as their comments to us directly and to our staff during community events.

Dr. Conroy Next slide.

Dr. Conroy Each of NYU's emergency department sites, we look for ways to engage with our local community. We are showing just a few of the things that we do as part of our community outreach for the Steinberg ED. Starting several years ago, again prior to the pandemic, we began having an annual health there on site. Unfortunately, as a result of

the pandemic and safety concerns, this had to be contracted down to essentially a flu pod clinic for the community, which was still very welcome and attended quite nicely by people in the neighborhood. We host these in partnership with some of our local government officials, including Assemblymember Joanne Simon, who's been partnering with on this for many years. We're also looking to expand this now that we're in our new facility and the pandemic, hopefully is no longer. We also participate at the Annual Atlantic Antique Street Fair every Fall. We host a table right on Atlantic Avenue to provide information to patients and answer their questions. We participate in local neighborhood association talks and community board, as well as our local Cobble Hill Clinical Advisory panel. Within our department directly for patients we provide direct initiatives such as diabetes screening for patients who meet criteria, as well as bike helmet distribution for patients who need it.

Dr. Conroy Next slide, please.

Dr. Conroy Looking to the future, we're very excited about the opportunity to continue to provide services to patients in our community. We're very happy to see that we continue to have growth in our patient volumes annually. We're looking to expand our telemedicine workflows to reduce the number of transfers. Again, to combat that lack of onsite consultants as well as look at the opportunity of having 24-hour observation patients remain on site with our 24 hour stay rooms. We're looking to increase our offerings at our annual health fair and try to partner with our other services that are now in the building to provide more services at these health fair, and more screening opportunities. As part of our routine emergency department goals, we're constantly looking at ways to improve and react, respond to surge planning and capacity management. We plan for potential mass casualty incidents and look for additional opportunities to provide, health care equity initiatives directly to our patients.

Dr. Conroy Last slide.

Dr. Conroy That's all I have. Thank you very much for letting us share this information. I don't know if we'll do questions now.

Mr. Kraut Thank you again. That was also very impressive. This is the first purpose built, rather than a renovated building. When you planned that building it was very, very focused on the needs of that community and what you experienced in the first site.

Mr. Kraut I'm going to work on questions. I'm going to start on that corner then we'll work our way down. And by the way, the members that are pending appointment. If you have questions, please engage. Feel free to join in there.

Mr. Kraut Dr. Berliner.

Dr. Berliner Yes.

Dr. Berliner Thank you for that excellent presentation.

Dr. Berliner I have a question. Over the next several years there's going to be a lot of work going on the Brooklyn Queens Expressway, which is going to divert people onto basically right past your front door. I mean, I know they've done some weekend work. Is that currently affecting your times to ER and things like that ambulance times to ER? What happens if basically it takes people an hour to get off the BQE?

Dr. Conroy the change in the traffic lanes along the BQE as well as along the Brooklyn Bridge has already affected the traffic around our facility for a couple of years now. It does get worse on those certain weekends when they completely shut the BQE down. That has been a question by the community as well. It really hasn't affected our ability to get transfers out of our facility. Part of that is because we do have that critical ambulance that's on site 24/7. If we have a critical emergent transfer that can't wait, we activate them, they take the patient and we're right by the corner of Hicks and Atlantic. They're really not being blocked. For routine transfers, you know, we have twenty-five to forty-five minutes for them to arrive to take a stable patient out. It has significantly impacted us.

Mr. Kraut Mr. La Rue.

Mr. La Rue Thanks, Jeff.

Mr. La Rue I'm going to follow up on the same question, because I think this is a great example. I think these satellite ERs are a great tool and asset for the community. My questions aren't about the necessity or validity. I'm just trying to understand the outcome data from a satellite versus a traditional ER. If it's tracked and how we compare that. When you look at this stroke flowchart here. You know, if you go to a traditional ER they think someone might be having a stroke. 100 people descend upon that patient. They realize they're not having a stroke. They all go back to whatever else they were doing. You identify somebody having a stroke. You intervene. You've got your telehealth. You give them the medication. You put them in the ambulance. You send them to a full hospital. Is there any data that indicate the outcomes for that patient versus someone who would have gone to a traditional ER? Again, I'm talking about a walk in because I understand what Jeff said the diversion ambulance isn't going to take you there if that's the circumstance.

Dr. Conroy We do have patients who walk in and occasionally a miss triage by an EMS team will bring a patient who's having new neurologic deficits that will activate a stroke notification. Because the role of our, like, basically our ED is the stroke team. We'll have instead of one-hundred people, maybe fifteen people descend upon this patient, get them immediately to CAT scan while we're simultaneously talking to our stroke attending, telling the ALS bus that's on standby we may have to transfer this patient out. We really are kind of doing multiple things at once. We do track this data. Our metrics for stroke are essentially the same as if a patient presented to either the NYU, Brooklyn ED or the NYU Manhattan ED. Our time metrics are exactly the same. We've been good at meeting those.

Dr. Soffel Good morning. I'm just curious about whether there are things that you cannot do because of the limits of your license, because there's no hospital upstairs. Or is it, in fact, virtually, you don't notice? Is there anything that you would see differently if you were actually a hospital-based ED, rather than being a freestanding ID? Do you understand the question?

Dr. Conroy I think I do. As the Chief for this site, I orient all of our new providers who come in. I really explain to them that if we treat patients who come into the Cobble Hill ED the same way we treat patients who present to either the NYU Brooklyn campus or the NYU Manhattan campus. It is slightly different for the patient, because if they're presenting and they need to consult they need a consultant for a service that we don't have available because we don't have consultants on site. That does require transferring them, but we don't limit their care. We don't change the type of care we provide because of that. The transfer is part of their visit. It's a continuation of their presentation to our location. It's just completed, and they're discharged from another facility or potentially admitted after

evaluation by the specialists there. Our emergency department meet monthly. We align our policies so that, again, all of our patients who present to any of our NYU departments we're trying to give them exactly the same level of care and treatment across the board.

Mr. Kraut Ms. Monroe.

Ms. Monroe Thank you.

Ms. Monroe If you're looking to the future you talked about that you need to combat a lack of onsite consultants. I would think that the larger system would have plenty of consultants. Are you having trouble getting those consultants to come to your site? What did you mean by this?

Dr. Conroy We've never had consultants on site. What we are been able to do with our telemedicine workflows for stroke and for psych, especially for psych to kind of bring that consultant virtually to our location and then potentially save this patient a transfer and subsequent discharge from another emergency department. As I mentioned, I think the number I said was thirteen or thirty-seven. I'm forgetting which one now of many of our transfers ED to ED are going for a specialty consultation and then subsequently getting discharged. We don't have the same volume of consults for patients that you would have at one of the main campuses. It doesn't make sense to have a surgeon or an orthopedist or someone else sitting waiting for a consult that may or may not come to them. With the use of telemedicine, they're still being staffed, and they can still respond to us virtually.

Mr. Kraut The same question we asked before. Obviously, you know, you described the community reaction when Long Island College was closed. Clearly, these are not a substitute for a full-service hospital. We did show the examples. From the community perspective, the ability to still get admitted doing those things. Do you think that that perception has changed dramatically? It sounds like you've really worked hard at it. Do you still get pushback from that community to kind of do more stuff like that?

Dr. Conroy the community was a little suspicious right in the beginning when we opened up. I do think that over time Nancy and her team worked very hard with the community. They really engaged them. They started to work with them and tailor services to them. You know, the flu pods are an example of that. Over time, I think the community has really come to embrace the new Cobble Hill ED. Especially with the opening of the new building, we found that the community has been very excited about it. We've gotten tremendous feedback. It's right on Atlantic now. It's on the main thoroughfare in Cobble Hill. Just visually it's right out there. We are getting a lot of positive feedback.

Mr. Kraut I'm going to just leave you with a question and I'm going to ask them the same question. We're going to come back at the end. Part of what we're looking at is changes in regulations or procedures or what have you. If you can give some thoughts are there things that you would be doing if you were the regulations permitted you to do, but you don't believe it allows you to do now? I don't even know what I'm talking about. I'm just basically going to ask you about that. If you can't answer it today we're going to follow up and ask you to write to us. Because we're looking for things that might create greater flexibility or, frankly, adaptability to community health needs.

Mr. Kraut I want to introduce Robert Ortmyer is the President of the University of Vermont Health Network and Elizabethtown Community Hospital. We're going to hear a slightly

different model and a little slightly different history, which I think will complement the other two presentations.

Mr. Ortmyer Thank you.

Mr. Ortmyer Thank you very much for having me here this morning. It's a pleasure to be able to present our story. As stated, I'm Bob Ortmyer, President for University of Vermont Health Network, Elizabethtown Community Hospital and Porter Medical Center. I'll reference the relevance of that as we go along here in terms of my dual role.

Mr. Ortmyer Next slide.

Mr. Ortmyer The discussion here today, you know, just like everybody else has done we're going to talk a bit about the development of freestanding ED after a hospital closure, some of our operating stats, how we've integrated into our current health network and any future implications for health care delivery.

Mr. Ortmyer Next slide.

Mr. Ortmyer Just a bit of background around our project here. I've been with the network for three years at this point in time now. This project had already been completed and opened by the time I got there. This is the former Moses Ludington Hospital in Ticonderoga, New York. That was a fifteen-bed inpatient hospital with a few ancillary services and for a long time really struggling financially to survive. They were seeking partners at that point in time and had approached University of Vermont Health Network to see if they could work closely, more closely together with them. Through lots of, as you can imagine, discussions/negotiations they affiliated with the Health Network in 2017, closed the beds. The leadership at the time at Elizabethtown, as this hospital was going to become part of Elizabethtown Community Hospital under the network framework applied for the transformation grants, VAP grants, and achieved a $9 million grant to demolish and rebuild the campus in Ticonderoga to be just an outpatient location satellite off of Elizabethtown Hospital. All that work happened. In the Fall of the of 2018, the new emergency department and clinic sites opened. I think it's very important to note, too, that within the community and seeing our colleague, Dr. Rugge here, Hudson Headwaters was and continues to be the primary care provider for adults in pediatric medicine in Ticonderoga. They were in a different location at that time. During the course of this construction also came on site and I was a part of this new location.

Mr. Ortmyer Next slide.

Mr. Ortmyer This just gives you an idea of the geographic layout of our network. We've been talking these last two presentations that basically you're in the city. We're going into the deep rural countryside here of Northern New York. Beautiful as it is it presents a ton of challenges that we need to deal with from a health care perspective. Ticonderoga is at the bottom left-hand side of your diagram there. Right at the top of Lake George and borders Lake Champlain. The closest hospital Elizabethtown or Porter Medical Center is 50 miles from there. Closest hospital South of that is Glens Falls 50 miles. This is the only option for this town. It's a town that's really off the beaten path. You've had to be very intentional. You're going to be going there. It's just not off the highway. Like I say, it's a beautiful area to be in, but presents challenges. Next area in which for a higher level of care if we have to transfer a patient out is Champlain Valley Physicians Hospital in Plattsburgh, New York, which is 90 miles away or across the lake to Burlington, which is 60. We do a lot of air

transport. I mentioned, I have two hospitals that I oversee, both critical access hospitals, Elizabethtown and Porter Medical Center. You see there the geographic location on here. The relevance of that. It makes up the Southern area of our catchment area. By combining our administrative and several clinical resources it allows us to be able to, number one, have a lot of cost containment. Being able to plan our clinical activities around how we address our community needs. A lot of the specialists that we get come from that get in Ticonderoga, come from Porter Medical Center or even Burlington, Vermont that rotate through Ticonderoga.

Mr. Ortmyer Next slide.

Mr. Ortmyer This is just an aerial view of the campus. The top right corner is the Hudson Headwaters space there and then running down the center of the building is where our emergency department, our specialty clinics, lab, imaging, pharmacy and outpatient rehab, all of us reside there. Obviously, you see the helipad, which is close and commonly used. Also on this property is a freestanding independent nursing home run by Elder Wood.

Mr. Ortmyer Next slide, please.

Mr. Ortmyer A bit about our location there in the Ticonderoga area sits within Essex County, a very large county in the Adirondack Park around 1,700 square miles. Only 38,000 from a population standpoint. 3,200 in Ticonderoga. Ticonderoga does have an influx of residents in the summertime due to Lake George and Lake Champlain. There's a lot of second property owners there. We do see an increase. From a demographic standpoint 93% white, 3% Black, 3% Hispanic and 1% other. There's not a very diverse population there. Unemployment rate about 4.7%. I think probably a lot of these health care priorities are a lot of the same as what a lot of people see. Chronic disease tops the list with diabetes leading the way there. Substance use, mental health issues are very prevalent in the community. Maternal and fetal health as well. Poverty also plays a key role here. Poverty in Essex County is around 10%. In Ticonderoga it's at 14.9%. That's a battle there.

Mr. Ortmyer Next slide, please.

Mr. Ortmyer The services... I mentioned what we have on campus there, the emergency department, we have five treatment rooms, four observation beds, lab imaging, outpatient rehab and pharmacy. The specialty clinics I think are really key here. Because these are services that would not have otherwise been a part of this community if it weren't for being a part of a larger network. Women's health, dermatology, cardiology, GI in orthopedics. If you went into this town and knew that you could see your cardiologist there you'd think this is fantastic. Who can get a dermatology appointment in Ticonderoga? I mean, again, that's another thing that's hard to fathom. As we can get more specialists to come here we will do that. I think we're challenged just like everybody else is. There's such a great demand for specialty services and much more demand than what there is the supply. As we can get additional docs to rotate through here we will do that. Again, they all come from being a part of our network. And of course, as I mentioned, Hudson Headwaters with their primary care and between Ticonderoga and Plattsburgh Elizabethtown Community Hospital has six primary care locations that are scattered throughout the Adirondack Park as well providing their services. We're 83 employees on that Ticonderoga campus. If you even just want to put it to scale, the Elizabethtown Community Hospital is made up with only 300 employees. It's a far cry from what we've been talking about. The ED in Ticonderoga, 33 employees. Number of visits 7,500. Our imaging 10,000. Procedures

there. That's our general imaging, CT, MRI and mammography. Lab tests are at 51,000, tests annually as well. I'll get into our employee engagement and culture safety in a little bit here.

Mr. Ortmyer The care delivery model really when this opened, it was really focused around advanced practice practitioners really providing the care in the emergency department with some physician's supervision. Now, we made the intentional decision to make sure that we have physicians, within our emergency departments 24/7. We've been able to accomplish that. Again, being a part of our network, when an ED physician is hired, part of the agreement is you work in more than one emergency department or six hospitals. You have your pick of where you want to go. You can work in Burlington where it's a bit busier, or up in Plattsburgh, again, where it's busier. You get a nice rural experience in any of our other hospitals. That has a really worked out well to provide coverage for the emergency department. We have a common medical record now. Everybody is now on EPIC within our network. 2021 is when the last of the hospitals came on with that. That has been key in terms of our care of our patients being connected with the same medical record. We talked to telemedicine earlier today. We benefit from the same being within Ticonderoga or really any of the hospitals, whether tele stroke, access to pediatric specialists, and trauma issues if we need to get a doc on the phone for an issue that presents in the ED. Nursing education. We really had to ramp that up. Being where we are with no other access to other professionals around for higher levels of care, really needed to make sure we had more training in critical and emergency care. That has been a definite advantage to be able to care whoever comes in the door. Talked also earlier about a transfer system or transfer center. We have the same thing within University of Vermont. That was really born there out of COVID and managing the patients among all the various hospitals because of how full everybody was. It has continued. Just because of census everywhere has stayed very high. That's never gone down. It's actually very efficient at moving patients around. They just make sure that you get the patient in the right bed at the right time. Again, I mentioned our specialists for consultations and our specialists rotating through the ambulatory care.

Mr. Ortmyer Next slide.

Mr. Ortmyer Really, when we got this project started for developing this in Ticonderoga lots of stakeholder meetings within the community, these communities really hang on to. You got to save our hospital. We need a hospital. This community in particular, because there's nothing else around and really did need one. They don't let things go. They still refer to Ticonderoga as Moses Ludington even though the signs and all the different work that we do within the communities suggests otherwise. We had many town hall events. Senator Betty Little at the time was huge at advocating for our grant applications in order to get that through. We had a lot of network support from the University of Vermont Health Network to integrate this campus within into our overall health system community.

Mr. Ortmyer Next slide.

Mr. Ortmyer Just to point out who our partners in all of our success were former Moses Ludington hospital board, the Elizabethtown Hospital board folks, network leaders, Hudson Headwaters, the Lord Howe Nursing Home and Adult Home that was on that campus. I mentioned, Senator Betty Little and also Dan Stack is now a very active as well with us as well as Ticonderoga community. We're very integrated within the Ticonderoga community. There was a bit of skepticism at the beginning. What's this health network from Vermont know about New York? We have three hospitals in New York and three in Vermont. I think

we've been able to pull those resources together and show the communities the benefits of what a health network can bring to them.

Mr. Ortmyer I just wanted to show you our patient experience data. This is just our Ticonderoga campus overall, patient satisfaction. In 2019, we started out the 90th percentile. You can see a nice steady growth the 96 percentile for patient experience.

Mr. Ortmyer The next slide has our culture safety on there. I wanted to just show. This is an old slide from 2016 when it was Moses Ludington. You're probably familiar with the culture safety survey HANY's puts out each year. Just a couple of areas to point out here, the hospital management support around culture safety at that time. This was in 2016. 62%. Teamwork among the hospital units was at 57%.

Mr. Ortmyer If you go to the next slide there's now more things they track on here. These are three-year gross. If you just look at the management views and support around culture safety. It's now at 88.5. This is our most recent survey that we completed. It's 83%. Marked improvements. Culture safety is a huge, huge focus of ours at Elizabethtown. It transfers to all of our areas, whether you're in ambulatory location or inpatient unit. It just drives everything that we do for our patients.

Mr. Ortmyer Next slide.

Mr. Ortmyer Just as a quick employee engagement index here. This past year, in 2023, we did our first network wide employee engagement survey. This is by the Gallup Group that did this. Across our whole network, there's a roll up their engagement ratio of 2 to 1. What's that saying? For everyone disengaged staff member we have two engaged. At Elizabethtown Community Hospital, which is all inclusive of all of our services we are of 5.8 to 1. For everyone disengaged, we had 5.8 engaged. Again, I think it shows the type of culture. What Gallup likes to look to see at the end once a year in a mature area is a 5 to 1 ratio. It's a blessing and a curse that we did this well in our first year of this. Because how do you hang on to that? We've been doing a lot of work to make sure that we can do that. We're actually in the midst of that survey right now. We'll get to see following, the end of our survey week next week how we've done.

Mr. Ortmyer Next slide shows in particular just the Ticonderoga campus. They finished with a 4.26 engagement. Again, very, very similar to what the overall Elizabethtown results were.

Mr. Ortmyer Last slide.

Mr. Ortmyer Everybody has these challenges. No matter who you talk to within health care recruitment and retention huge issue. We could not go it alone in Ticonderoga without being a part of the network. You know, without having great partners there so that we have access to, shared services of different administrative assistance. Our clinical rotations that we get through there has helped provide services to the community that they otherwise would not have. Housing is huge. It needs to be affordable housing. We're in a situation up in that area there where, we say it's two- or three-bedroom home you're going to build, but that two- or three-bedroom home to build that home now is $500,000 to $600,000. The average health care professional can't afford that. We need affordable housing. This is getting addressed in Ticonderoga. They're very fortunate right now. They're having about 200 units that are going to be constructed over the next couple of years. Ticonderoga has also been recipients of $10 million revitalization grant by the state this year as well. They're

one of the lucky communities, I would say up in the North Country that, I think can see a glimmer of hope. It's very difficult to recruit professionals to that area. We're all seeing our demographics, age. All the young people that graduate school and they're gone. They don't stick around. We need to be able to offer something that's attractive. We need to offer some new industry in the area to keep people there. There just aren't high paying jobs. You couple that with our housing shortage. It makes it very, very difficult. We still rely a lot on travelers. I say a lot. For Elizabethtown having twelve to fifteen travelers is a lot. It's a very expensive for a critical access hospital. At Ticonderoga, we have a couple in our emergency department from a nursing standpoint, radiology from a tech standpoint as well as our lab staff. Very expensive options. Again, you can't recruit people to the area. Post acute resources is another thing. I mentioned nursing homes. There's not enough of them. There are not enough nursing home beds. Again, community is getting older. No one wants to leave their communities. We need good post-acute resources. I know folks had mentioned transport, the inter facility transport, if you can imagine, minimum 50 miles from any other health care facility. We have a transport at Elizabethtown. We also have a paramedic education course that we do on an annual basis that puts out about 18 new paramedics into the community each year. They go throughout all of the North Country. Up there, everybody has these challenges. It's still not enough. It's a big challenge. Thank goodness we have air transport as well to get between facilities. Issues are real. The resources are extremely limited. Very, very, proud of the work that we're doing for the communities and for the dedication, really, that the staff have. Again, in our engagement from our staff, I think you can see that they just had the best interest for our community.

Mr. Kraut Thank you very much.

Mr. Kraut Do we have questions?

Mr. Kraut I'm going to start here and then work my way around.

Mr. Kraut Yes, Dr. Rugge.

Dr. Rugge Just as a comment. I think what would happen in Ticonderoga over the years and decades was the same thing that's happening everywhere. It is many services which formerly had to be provided in an acute care setting now go to the office setting or go to the home setting. In Ticonderoga, this became particularly market because any decrease in volume and any decrease in revenue would make it unviable. Familiar story with you. What's special about the Ticonderoga story is that the local state senator happened to be the Chair of the Finance Committee. Every year there was just enough money allocated for the hospital to keep it in service. Two things happened. The numbers became worse and worse. It simply became unviable to continue this kind of subsidization. Senator Stafford retired. What that led to be a community wide discussion of what do we do now? What's going to happen? Where's our hospitals going? What services do we need? I know because I lived it. Time after time there were town hall meetings, and the town hall meetings were expressions of hopelessness and rage. What can be done? As an outcome everything that Bob has described coming together, bringing specialty services that were never there before, emergency services that are there as good as they've ever been or better. This community is proud of the services it has and is relieved to gone through this transition, which was extraordinarily difficult. I think for us the challenge is what can we do to provide any help or consultations or advice in terms of how do we make those transitions from one kind of service to another easier and viable and doable? This is an excellent model for how it can happen. It should happen gradually over time rather than a cliff.

Mr. Kraut Thank you.

Mr. Kraut Dr. Boufford.

Dr. Boufford Thanks very much.

Dr. Boufford These are great presentations. I think you touched on with my colleagues' good questions. One of the anxieties initially about having the notion of freestanding ER. I congratulate all of you. My question is slightly different. I think when my colleague Peter Robinson mentioned earlier are we sneaking into micro-hospitals again because of the reality of what you're dealing with? I have a slightly another question is are we sort of giving up on primary care and beginning to think about this is the new model for ambulatory care? I make the distinction. Ambulatory care being walk in visits. Primary care being continuity of care. I think you indicated that you have on the campus primary care practices and others if you have networks. One of the things we've been interested in in other contexts is John's been having some hearings. We know for thirty years or so, probably 30 or 40% of people who actually go to an E.R. don't need to be there. They could be in their primary care, you know, treatable illnesses, preventative illnesses. Because the primary care is inadequate they don't get that care and they come to you. I'm trying to ask each of you to sort of reflect on that issue. I think you indicated. We've talked before about the role of sort of doctors' offices and pharmacies and others that are providing care to people more conveniently. Is there a referral basis to a primary care practice? Is that no longer relevant? I mean, is that some of your ER docs who are running systems around the state have said, look, if we could get out of the business of only doing emergency room responses these are not you guys. We would. That's we're really filling this gap. I think one of the big policy gaps that we've struggled with is really provision of primary care services other than DTC and sort of the other sort of formal Article 28. I want you to talk a little bit about the issues of that sort of ambulatory walk-in outpatient visits. Is their primary care follow up? Is that an issue? Would that be something that you would wish to take on?

Ms. Feiertag Thank you for that question.

Ms. Feiertag We do not want patients that shouldn't be in the emergency department. We're in the process of adding thirteen more primary care providers to our geography. We also have a very robust referrals coordinator program in the emergency department. Anybody that leaves the emergency department and doesn't already have an established primary care provider we schedule a direct appointment. If they need specialty care, we schedule that as well. We are really trying to build primary care so that patients can get that preventative care at the place where they really should be, especially from a financial point of view. They're going to get an emergency department bill if they come to our emergency department. It's just much better to keep those patients in our outpatient physician practice settings.

Dr. Boufford I noticed some of you and your physical plants have physician practice offices on a particular floor. Will these be on site there or in these other little nodes that many of you have around your sites in the geographic area?

Ms. Feiertag We do have primary care services on the sixth floor in our building, but also across the street and again in Manhattan everything is within a mile of each other. We have eight or nine primary care sites in that immediate area.

Dr. Boufford Can I hear that from the other two?

Ms. Feiertag We also have a pretty robust referral for outpatient follow up after emergency department to either primary care or a specialty service that's required. We do have services available on the second floor in our current facility. We've also over the years NYU has developed additional offices in the neighborhood, both for our faculty group practice as well as our family health clinic. We're able to refer patients with any type of insurance to the appropriate location. We actually have in our emergency discharge workflow an option to select an ambulatory rural to primary care or internal medicine to help get patients set up with a primary care physician.

Ms. Feiertag Just one last comment. I'll just add that we have a very robust ED follow up call program. All of our patients who go to any one of our ED's are contacted after they're discharged to make sure that if they you see if they need help scheduling an appointment or any other services.

Mr. Ortmyer I'll just echo, what was previously said. We don't want additional patients in our E.R.. We're constantly or always in the process of recruiting for primary care physicians. Our geography is so spread out. Number one, patients couldn't get themselves to the ED if that was going to be it. Transport's a huge issue. What we are seeing is and the community has really been very responsive to this. No matter whether it's in Elizabethtown at that emergency department or in Ticonderoga. They're not using that facility as a primary care office. They go to their primary care office and seek their care there. We're seeing that the people that are coming into the emergency rooms they are really sick. The acuity is much, much higher than what it used to be in the past.

Dr. Boufford I just wanted to just to finish up on this, the line of questioning. I think one of the issues you mentioned earlier in your presentation that one of the facility's freestanding facilities have been shut down because of lack of appropriate acuity using it. I think the volume of acute care patients you mentioned. I'm just wondering if there's another piece that ought to be looked at relative to the robustness of referral to primary care or other issues for these facilities in terms of their role. Because I just don't want to sort of the not this is not a critique at all. It's just a statement. I think one of the issues of the unintended consequences, since we know we aren't investing in primary care practices in a way we'd all like to, it is difficult to get primary care physicians out of the med schools these days. Having been a primary care pediatrician I can speak to, that it's frightening seeing the number of kids that are going into family medicine or general medicine now. We need to watch this. Is it only going to be these facility-based situations, which is okay, but it just needs to be part of our thinking and these looking at these facilities. I really appreciate your presentation. Thank you.

Mr. Kraut I think this is just another one of those issues we'll come back to. One of the things that's striking me, these are all organizations that have systems of care behind them. There is scale here. There is opportunity here. I think that is part of that. We saw that certainly during COVID, the resiliency of those that had that structure and infrastructure. You've heard some of the investments. Maybe we'll come back. That's one of the items we'll put on the list here about primary care and maybe how it's organized and deployed.

Dr. Boufford Sorry, but just I think one of the real issues here this is just fundamental to the cost of the health care system is part with absent a more of a sort of managed care

framework across the ensuring insurance systems. We clearly are still filling beds through our primary care outposts. I think that's a dilemma versus paying for prevention or promoting prevention.

Mr. Kraut Dr. Kalkut.

Dr. Kalkut Thank you.

Dr. Kalkut Those were three great presentations. I'm particularly interested in hearing about the rural system. I think what one theme that crosses the three, is, as Jeff said, these are members of systems and have backed up that can be called upon and like the operational sophistication that all three of these have to make this work I think is an absolute key to success safety, quality, access, whether it's central call center or telehealth or being able to transfer quickly makes these kind of organizations, systems, facilities, that I think would work in other places extremely well. You have to have, I think, two parts, sophistication, understanding technology to have the service meet the needs of patients who are walking in, patients who are getting, brought in by ambulance and create trust with the community that you operate in. Congratulations to all three of you.

Dr. Berliner Could you explain to me what an actively disengaged employee is? I'm particularly interested in how that corresponds with your quality of safety initiatives.

Mr. Ortmyer Thankfully, we don't have a whole lot of actively disengaged. It's a measure with how Gallup looks at whether you're engaged or not in your overall work. Are your basic needs being met? Are your job expectations clear? Those types of areas are focused on do you know what's, expected of you at work? There's a rating scale. It's attached to that. It's a one through five. That's just how it kind of flushes out.

Mr. Kraut Doctor Lim and then we'll go to Ann.

Dr. Lim Thank you to you all for the great presentations.

Dr. Lim This is a question, a two parter. I apologize if you've already spoken to some of this and I missed it. Can you explain a little bit more about in terms of volumes of people who are coming in with primary substance use and or mental health conditions as a reason for the visit? Secondarily, if you do know, you know, what is the availability of CPEP or psychiatric needs in the county, as well as the availability of general outpatient mental health and substance abuse services in the area? I just don't know. It's just really helpful to understand the picture.

Mr. Ortmyer We have a good partnership with Essex County Mental Health. They're located in Elizabethtown. If we have patients who present to the emergency department, whether it's in Elizabethtown or Ticonderoga they will come on site to do an evaluation if necessary. Sometimes a phone call will be enough. They do have an outpatient office in Ticonderoga that they come a couple of days a week so that that is available to that community. It's not enough. Psychiatry is by telemedicine only at this point. We don't have any psychiatrist on site. Elizabethtown has been actively recruiting for two years for a psychiatrist. We've had one applicant. It takes a special individual.

Dr. Lim I understand completely. It's not a unique situation.

Mr. Ortmyer To want to live in a rural area like that when they have many choices where they can establish a practice. It's a challenge. Fortunately, we don't experience the behavioral health issues that some emergency departments do experience. The other hospital that I work with at Porter Medical Center. We have significant psychiatric issues there. It's only 50 miles away. Why has one experience it and not the other?

Mr. Kraut I think that's one of those issues we have to come back to.

Mr. Kraut Ms. Monroe.

Ms. Monroe Thank you.

Ms. Monroe This was very interesting. I'd like to bring it back to the work of the council. As I understood it, when you introduced this idea, this concept, you said that we at the council asked for a report, a progress report at a certain period of time. I'm hoping that in the future we could be more specific about what we're looking for. We heard Mr. La Rue talked about outcomes that he'd like to see. What is the timing for a feedback report? How do we know what other ones are out there that we might have asked for, but we haven't received? Can we put that on our agenda?

Mr. Kraut Only the NYU and the Northwell approvals had a requirement to provide an annual report for a few years that they did file that with the department. It contains a whole bunch of statistics and information that is about transfers. All of that data was provided by the applicants as part of their approval. It was a contingency that was or condition/contingent. One of those things that it was attached to the approval. We never were able to sit and talk to them. That's why we asked it to do it today. The only two in the state that ever had those conditions attached.

Ms. Monroe Oh, I misunderstood you. I thought you said when we began to approve these, we wanted to report back.

Mr. Kraut Yes, because we never had approved two in an urban setting.

Ms. Monroe Beside the point, I think---

Mr. Kraut You're right. I hear what you're saying.

Ms. Monroe If we have a request for feedback, I think we should be specific about timing and what we want covered in that feedback so that we have both a written report and the added value of an opportunity face to face.

Mr. Kraut I'm going to put that on.

Mr. Kraut Was there another question?

Dr. Friedrich These great presentations. I'm talking here as a patient as a word of caution about thinking is there a role for the health department to make sure that patients understand that these freestanding ED's are interim ED's? There is no hospital in the same facility. You mentioned stroke, for example. The evidence on stroke care goes clearly into timely intervention, especially thrombectomy and so forth. I'm just worried in the future about cases, the, you know, 2%, 98% is probably very well taken care of in your facilities. That have the assumption as a patient to walk into a facility and they think they

get the full care in this facility, these emergency cases, who are timely, who need to be transferred timely. I feel that these interim ED's might not all the cases but very few cases be just a waste of time for the patient. My question is for the health department, for Dr. Shulman, Dr. McDonald. Is there a role for the Department of Health to make sure that the public understands that these are freestanding ED's with limited, I would say limited services for the patients who are accessing these facilities?

Dr. Conroy I'm glad we're just having a quick conversation about stroke. As we've mentioned before, we're not 911 receiving for stroke. EMS is not supposed to bring our stroke patients. However, we do receive stroke patients and our door to CT's and our door to T and K times are equal to or better than those of our sister hospitals. We applied to become certified through the Joint Commission as a primary stroke center. Lenox Hill Hospital is a comprehensive stroke center, but we are not part of that. We did receive approval from the Joint Commission as a primary stroke center, but we still have not received approval from the Department of Health to be 911 receiving, for stroke. We're hoping that when we open our eight inpatient beds and we're actually able to discharge stroke patients from the inpatient setting that we will be able to get 911 receiving capacity, because we think that actually if they can get to us fastest then that's going to lead to the best outcome. We don't have the ability at our site to do thrombectomy, but the window and requirements for thrombectomy is long enough so that we can get that patient their T and K and get them in the ambulance and send them if they actually do need thrombectomy.

Dr. Soto I have a recommendation as we look at increasing the number of individuals having primary care and having access that we also look at the information on how people navigate health insurance. Many individuals end up in the ED as a last resort. Some of them are because they don't have insurance. The insurance enrollment process can be very challenging. It was interesting that the NYU Cobble Hill, in your presentation, you indicated that the individual's ability to pay is not an issue. I think it's great individuals are giving referrals. How are they going to afford going on to that referral? I think that's something that along with access or that you're getting a referral how can you afford that.

Dr. Woods We're designated as a primary stroke center by Joint Commission, but we're not designated as 911 receiving. We don't have that 911 receiving stroke designation.

Mr. Kraut I didn't even know this. Is that application pending? Is it submitted to the department?

Dr. Woods It's pending, but it'll probably wait until we open up the inpatient units.

Mr. Kraut It's not ready for prime time yet. You haven't submitted to the department yet? Only when the beds are certified you're going to submit that. We have the department here we might as well just ask.

Dr. Woods Right now it's sort of on hold. We think when we open up the inpatient units we're going...

Mr. Kraut I want to thank all of our presenters. I want to thank the council. I'm going to just ask one last question. It's unrelated, but it's two issues that have come before us. University of Vermont, Guthrie, UPMC are out-of-state providers. We always get concerned about their commitment to New York. Does that border matter? It sounds like from what you said, University of Vermont has been a consistent and strong supporter of

New York health care just as it has probably in Vermont. Is there any reason to believe that's not the case from what you've said?

Mr. Ortmyer Again, a resource standpoint, we're really providing a lot of services to our New York hospitals.

Mr. Kraut Because it comes up every once in a while and I just thought I'd take that opportunity while we're here.

Mr. Kraut We're going to take a break.

Mr. Kraut I got to move us on.

Dr. Rugge As a board member of the University of Vermont Health Network, I can tell you that New York is very much included in all those discussions. There may be opportunities with the ahead program to connect initiatives in New York with those in Vermont.

Mr. Kraut John, I had no idea you served on. That's wonderful, because I think that's an important thing in this room. We always have concerns. I think we've seen examples where it works well. Thank you.

Ms. Horrocks Currently, EMS is not done on a case-by-case basis of what can be taken there. It's a standard across the board for off campus emergency departments that no advanced life support patient can be brought to those facilities. There may be a need to rethink that. Currently, that's the standing. That's because from an EMS perspective, it being 1,900 different agencies in the state. It's very hard for them to decipher which hospitals can do which. We don't have a level-based system like the trauma system, for example, where everybody knows what a Level One does and a Level Three. ER is an emergency department. Really, the only difference in levels we have is you're either hospital attached emergency department or you're an off-campus emergency department.

Mr. Kraut Maybe that's something we can revisit in regulation. I think that that's a great thing. Just for a nomenclature issue, the word freestanding emergency department is not appropriate in the conversation we had. We should use the term satellite or off campus. That word freestanding is a difference with a distinction. As you saw the regulations, only the regulations permit hospitals to have satellite or off campus facilities. The public doesn't misunderstand this conversation. We're not looking to approve freestanding unaligned facilities as they occur across the rest of the country.

Mr. Kraut We're going to take a fifteen-minute break while we reset the room. You get to use the facilities. Again, I can't thank you enough for this conversation. It exceeded our expectations.

(Clapping)

Mr. Kraut We're going to push lunch a little, obviously. Best planning goes out the door. Fifteen minutes guys. Come back about five to 12:00pm.
Mr. Kraut Here to introduce Dr. Eli Rosenberg, who's Director of the Office of Science. Dr. Rosenberg is going to talk. He'll explain this presentation. We want to talk about bringing data into the conversations, more data. Good data delivered in a neutral way drives good policy. You heard Dr. McDonald this morning talk about the 435 data basis that was resident in the department and how they're trying to modernize data. We know there are

issues concerning the timeliness and availability of data, which the department has worked on to make them more available. We know we have invested millions, probably $100 million in the all-payer database, but yet have not been able to access it for a lot of activities. Part of our conversation today is to understand some of the data structures that the department is doing, some of the things they're doing with public health data. Our job is to help liberate that data and to maybe create regulations that permit the liberation of that data, so it's used in a very big directional way.

Mr. Kraut I'll turn it on to Dr. Rosenberg and to start his presentation.

Dr. Rosenberg Great.

Dr. Rosenberg How's the sound now?

Dr. Rosenberg Good.

Dr. Rosenberg Thanks for having me today. I like that data liberation. I'm going to need to find a way to use that.

Mr. Kraut It's yours.

Dr. Rosenberg Well, thanks for having me today. I'm with the Office of Science, which is within the Office of Public Health under Dr. Bauer's leadership. We deal with a lot of those databases, 400 databases. We have the privilege of working with and summarizing, advancing various projects with those data sources. We had two topics for this session, but I'm we're also cognizant that a data presentation before lunch is a little bit fraught. We're over time. We're going to fast forward to Part II. The first topic was just sort of letting you in on some of our saga that we've had here at DOH with understanding the population composition of New York. Something that should be sort of easy, right? How many people live in New York? It turns out is a really hard question. One that we've been struggling with as the census has been going through gyrations in their estimates and methods, and with their spins and turns regarding the census, particularly the 2020 census and the errors that came up in that process for them. We've had to pivot and adjust our approach and our work. Obviously, it's boring. It's counting. It's people. Those are denominators for our disease rates. That tells us what our trends are. If we have any significant inaccuracies in those rates all the data we put out are affected. It's important for us understanding our trends and where we're going and where the places need is. Again, impacts allocation decisions, resource decisions as well. A sort of dry issue with big impacts that we've been struggling with. Those are in the hard copies if you want to see where we've landed in that process and what some of the issues were ahead of that. It's a demographic issue that we've been working through, and we wanted to sort of share with this body and get some feedback on the work that we've been doing there. That's around how do we assign residents to parts of the state? How do we come up with a reasonable regional strategy for describing our state in terms of data trends? I'll show some images of other earlier attempts at this. Really, there's been a myriad of schemes that have been put forth from DOH, but also other state agencies. We'll get there in a moment. I'm doing my long preamble first, then will advance the slides. There's been a number of earlier schemes that have been put forward, but none of them quite work for public health purposes. We've been trying to pursue a data driven strategy for coming up with a reasonable way to apportion our state and to regions that let us describe at a level between statewide and county level the trends that we're seeing across disease indicators.

Dr. Rosenberg Next slide, please.

Dr. Rosenberg One more slide.

Dr. Rosenberg We at DOH, we divide the state into these four regions. These are our four regional offices. This is the way that we sort of split our, in the coarsest way our work around New York State. That's the Western Region on the West. Obviously, the pink is the Central Region. We have the Capital Region, which is the blue, and then our Metropolitan Area, which is in the green. This is our most basic view of how we work. This lumps together a very, very diverse areas and populations in a way that may not be very useful for describing patterns around our state. Many different cities, areas, peoples and so forth get lumped in this classification.

Dr. Rosenberg Next slide, please.

Dr. Rosenberg as I mentioned, there's been a number of attempts to regionalize the state. Here's two very different maps that have been used before. On the left is the regional scheme. On the right is the Regional Economic Development councils or the REDC scheme. Both have pros and cons and things going for them. If you just see optically they're actually quite different in terms of how they treat a number of areas of the state. Picking on let's say the Binghamton area, the Southern Tier, you'll see that there's a very different way to sort of move around the various counties on the Pennsylvania border between those regions. Looking West of Albany there's a number of very different treatment of the region between Albany and Utica, for example, between these two schemes. The right one as the E in REDC implies it was developed really around economic development and for other priorities outside of the health department. Maybe that agglomeration of counties made sense for those purposes. The left is the scheme. Obviously, it was made with health in mind. From a prior Medicaid program and not necessarily made with public health goals in mind. It's now obviously from an outdated program.

Dr. Rosenberg Next slide, please.

Dr. Rosenberg the REDC scheme, that one that was on the right beforehand was adopted by the department and really by the state as a whole during the COVID-19 pandemic as a way to operationalize the response to the pandemic, but also as a way for describing data. It actually became a standard that was used for all of our COVID-19 data in reporting. If you went to that hyperlink, which obviously you can't because this is paper. If you clicked on that, you would get to all of our COVID dashboards and so forth that breakout a number of issues with the pandemic via testing, hospital data, wastewater data and so forth. Those all breakout the state into these REDC regions. There was a lot going for that in the sense that it offered a more granular overview of the information. You can see local trends and be responsive to what's going on in one part of the state or the other. For COVID, it was such I mean, really particularly in the first wave it was a very regional, situation. This really helps us be nimble if we can see local patterns and be responsive to that. As I said before, this was a scheme that was sort of imposed on the department. It really wasn't an epidemiologically driven approach to the scheme had been come up with. Really, it really it was an outside framework that had been utilized. Really, importantly, actually crossed our DOH regional office boundaries, though that original map of four that we saw before. It violated sort of the way we worked as a department. Our county partners were none too happy as well, our county health department partners who were put

together in new ways in this scheme, this REDC scheme that were in violation of sort of the prior way they worked under the regional office schematic.

Dr. Rosenberg Next slide, please.

Dr. Rosenberg What we wanted to do was actually come up with a new approach that respected our normal way of work, which is within those four regional office boundaries, but also actually did offer some of what we saw as advantages in that REDC scheme, which was the ability to go granular and look at local data and come up with actionable information at the local level. Again, something a little bit better than the sixty-two counties, which is often too fragmented to really see a cohesive picture out of. What we set out to do was come up with a new schematic that we'll talk about in a moment that maintain the integrity of the office boundaries, but also used other data. I'll show you how we used other census information. That considered the economic and social ties and areas to come up with a new sort of data driven approach to coming up with the county's scheme. What is really important is seen in the tiny print up there on the slides, also tiny on paper. You can look at it maybe a little bit easier. We really wanted it to be informed by stakeholders. We went through sort of a very methodical process of speaking with our county health department partners through NYSACHO at different levels, having conversations within the health department with programs and with leadership and now today with you. We really wanted to make sure that we got a lot of input into this scheme to make sure it made sense for the work that everyone's doing. We've gotten some good feedback along the way that we've incorporated and refined. We've been refining this.

Dr. Rosenberg Next slide, please.

Dr. Rosenberg We came up with a recommendation that's on the next slide. This is where we're at today. Again, I just want to just say. I said this earlier, but just emphasize we're proposing this map for describing data and trends and so forth. It's not meant to change how we do business or to change how we give out money or any major programmatic decisions. It's really around coming up with a logical scheme for describing the communities of our state. In that regard, we've come up with what we're tentatively calling the Census Informed Subregional Schema. I think we need something a little flashier than that. We'll come up with a little bit of a better name. It is what it is, which is that it's a census informed schematic. It divides the state into eleven regions. What is implied by the colors. Let's take the Western part of the state, for example. You see there's like a red and a pink. What's implied by those colors is we've actually subdivided the four DOH offices into smaller units. The red and the pink are both shades of what is the Western Regional Office of the Health Department, but is now broken into two, which is just for now just called the Eastern and Western Subregion of that Western Regional Office. Likewise, the Central Regional Office is broken into three shades of blue there. The Capital Region is broken into a Northern and a Southern component sort of split. It's sort of split halfway through there. And then the Metropolitan Regional Office is likewise split a few times into Long Island. There's a Lower Hudson, the Mid-Hudson and then New York City. There are a few splits within the Metropolitan Regional Office as well. What this does is it offers a way to sort of split out within our regional offices further. The numbers there are showing the population distribution of New York. It actually is a relatively balanced across the regions as best we can. Respecting, obviously, the Metropolitan New York City area is going to have a lot more people. You can't fully balance that out as it were. We don't have what we had in some of the other regional schemes, which is areas with not too many people in them. Importantly, this aligns with all of the Metropolitan statistical areas in New York State. I'll show you what that what I mean by that in a moment. It really aligns with

how the Census Bureau is also apportioning areas of the state into natural areas. Again, this has been the product of a lot of feedback.

Dr. Rosenberg Next slide, please.

Dr. Rosenberg It doesn't come out super well on this map, but you'll see there's little yellow, little yellow markers that indicate where we have hospital facilities as well in New York State. The summary table also shows the distribution by the subregions of hospitals as well. We wanted to make sure that we had not just a distribution, a good distribution of people. We also wanted to make sure the facility is well distributed across these places. Obviously, we can't fully control this in terms of how we make a scheme. We were pleased that at least all regions do have at least four hospital facilities as well contained in them. Again, the most are located in New York City and sort of the Metro area.

Dr. Rosenberg Next slide, please.

Dr. Rosenberg What we could do with this, and this is just an example is offer new ways to look at our information. All the information in these panels is COVID-19 hospitalization rates as sourced from our survey and shown in our dashboards. The upper left corner is a statewide view. What you start to be able to show now is we can go break out into the regional, the four DOH regions and start breaking out further within that as you go from, I guess sort of clockwise from regional into the capital region. You can go to Capital Region, Central Region, Western Region, and subregions and so forth. You can start breaking out within those regions those sub areas that we talked about and see areas even within the broader DOH regions. What are trends going on at more local levels as it were. This shows you just sort of some of the things we can do with this. Obviously, we can describe many more diseases in many more ways with this kind of system. Again, right now if you went to our website, you would see this done by the REDC regions, which is this system really introduced during COVID and sort of only used for COVID. We want to come up with something better. We think this is better.

Dr. Rosenberg Next slide, please.

Dr. Rosenberg Just to just briefly touch on what was the rationale for this. Again, that left most map is the DOH Regional Office scheme of the four offices. An initial map that we considered was an existing way to split the state, which is the Ryan White Program Regions which are used for federally funded HIV programming here in New York. We thought that this was actually a pretty good starting map in the sense that it already respected the four region boundaries for the states and offered a good sort of starting map, as it were for how to consider communities further. It had some issues that we wanted to work through. If you notice, the Capital Region is still awfully large. We thought that was a little too hard to cover that kind of expanse within one system. We thought that was actually a pretty good starting map and one that was, again, already used for some of our programming here.

Dr. Rosenberg Next slide, please.

Dr. Rosenberg What we next sought to do was then start to take that map of the Ryan White Region and resolve it against how the Census Bureau considers the state of New York. And to do that, we have to just absorb a little bit of jargon, which is how the census talks about places. When they do that they use different words. One is core. A core is an urban area with population 10,000 or more. There's something called the core paced

statistical area, which is a core county plus any places that they deem to have social and economic integration with that core place. That's through looking at data sets that they have on social and economic activity. They can put together places. Say, hey, look, people in this county tend to commute to that county or that they work or play or get educated in these places. They attach places to these cores based on those data sources. A number of data sets are used for this, including the decennial census 2020, which if we had more time, you would have heard me talk about in the prior section and then the American Community Survey, which is a sample survey that goes into a lot of depth beyond the decennial census. What happens is the Census Bureau looks at all these data. They come up with their concept of cores and what's called Metropolitan areas and so on that we'll see on the next slide. Every ten years, they revise for the entire United States what they call statistical areas, core base statistical areas. They come in different sizes these statistical areas. The one that's probably the most well-known is what's called an MSA or a Metropolitan Statistical Area. That's an area associated with an urban core that's larger than 50,000 people. There's something called the Micropolitan Statistical Area, which is the next size down. That's areas attached to a core between 10,000 and 50,000. There are the combined statistical areas, which actually are sort of greater regional designation. So, for example, New York City Metro Combined Statistical Area includes parts of New Jersey and Connecticut. It's just the Goliath of an area according to them. This map on the on the right sort of shows an example of how they do this. You'll see that that's the Albany, Schenectady, Metropolitan Statistical Area on the right. There's other sort of smaller micro areas around it like Gloversville and Amsterdam and so forth. It's hard to see it on the here, but there's a thick black border that puts them all together into a combined statistical area to represent the entire sort of Capital Region. It's a little bit of a weird jigsaw.

Dr. Rosenberg If you go to the next map, what the census does is they make something like this. It's a little ugly and not very useful for public health, but this is their way to carve up the state into distinct areas of cohesive activity, basically. They define areas like we were looking at on the Eastern border there, the Albany, Schenectady Combined Statistical Area. You see the New York, and Newark that was that combined statistical area on the bottom. That's that mega New York City Region. Within that there's the New York City Metropolitan Statistical Area and so forth. They produce information like this, which does not give us a scheme for public health, but it does tell us at least how parts of the state do hang together according to their data.

Dr. Rosenberg On the next slide, what we essentially did was... I don't have all the slides for this because it was a lot of steps. We essentially resolved what Ryan White map. We moved counties around such that they completely squared away with that map I showed you from the Census Bureau on the slide prior so that we moved counties into subregions. There are some animations there. We're going to skip those. There was basically some movement and horse trading, as it were, around the state such that we had a new map that respected all of those social and economic ties that the Census Bureau had laid out. There was a lot of discussion. Again, with partners along the way. Those little flags, for example, represent one movement of three counties in the Western part of the state that came from discussions with health department partners on that side. Those three counties, by the way do move between multiple regions often between the various schemas that exist.

Dr. Rosenberg On the next slide, just to give you a little just a taste of the nightmare that this actually is. These are some of the many ways that already exist for dividing up the state according to different programs throughout the health department and throughout the state government. First of all, the number that regions column says how many ways that

the state is split according to those entities. The one that's CBSA violations just shows you all the way that it sort of breaks the census-based scheme, violates sort of how the census considers the state of New York divided. Again, what we were trying to do was get that column to zero, so that we really had a system that made sense for what we were doing in New York in our regional offices, but also squared with the federal data on how to divide the state of New York. Not to say these are bad systems, they're just different. What we're trying to do is come up with something for our data that really works well for us and all the purposes that we have with presenting our data.

Dr. Rosenberg With that, I want to say thank you. I have two thank you slides. The first one is actually to recognize Ethan on our team who's the real engine behind this. He's always welcome to feedback either directly or you can give it to me.

Dr. Rosenberg My slide is next, which is the me. Thank you for your time today.

Mr. Kraut Thank you so much.

Mr. Kraut I'd like to start the questioning. This is the challenge of how the department looks at data. For the Public Health Council, we may look at a level below what you're doing. I would say generally, you know, given the challenges you had and some of the rationale you had, if this works, if this is the consensus for the department I don't think we're in a position to argue that point. It is at a very high level. We're talking about data about communicable diseases, the feeds that you get from either. I don't know if they're coming from hospitals. I don't know where you're pulling it from local Department of Health. It's all the public communicable disease reporting we're doing. What I think is tremendously valuable as you conceive the system is the data comes in and if it could be maintained at and tagged because you have to build up the locational, right? I don't know if you use zip code, or you geocode the file with the patient address.

Dr. Rosenberg There's a lot.

Mr. Kraut I know.

Dr. Rosenberg We have 400 databases.

Mr. Kraut Right.

Dr. Rosenberg In general, we're building up from record level, zip code or county level information. That's usually our starting point. Geocoding is often not done for a lot of our dashboards and reports. I think that was your first question. It's generally starting at that level. It's very dependent. When we look at, for example, the COVID data that's actually from the hospital survey, which is completed by facilities. We actually in the current iteration are showing it really by the facility location. That's actually rather unusual. Most of our other information is displayed by the patient residents. That will often be you can zip code or county level.

Mr. Kraut My point is, and I think if... We can ask the other members. In order to make the information actionable at the provider or the county Department of Health level, I think that the data can be aggregated in any way that makes sense for statewide reporting, but we need a data system that allows providers, community based organizations, the public, if you will, to be able to access and aggregate it in any way that makes sense for how they deliver care and to do things. As you design the system, what I would want to do is I'll take

a look at Nassau. If you look at it at Nassau County, if you look at it at the region that we would be in, which is kind of the purple region. It excludes New York City, right?

Dr. Rosenberg It's Nassau and Suffolk.

Mr. Kraut Just Nassau and Suffolk is 2.5 million people. If you just looked at it at that level you would not see the differences in eleven communities that have the worst outcomes because on average we're going to look great. We always do. That hides the problem. I think the challenge for us is we need to access the data at the smallest level so we can construct and look at that community and develop solutions that are tailored to the bigger trends that I think we're worried about at the state. I'm an advocate of geocoding at the census track level. We have data streams. Data is geo coded. The all-payer databases could be geo coded. Everything that's running through the New York Health Collaborative could be geo coded at the census track level and allow us to construct it. In my opinion, as long as the Department of Health and particularly public health data is available at that low level, and you'll hide anything with a cell size less than seven so it's a privacy issue. That would be the ideal way for data to be shared and made available in the state. I believe it will generate accountability, oversight and innovation and execution. I think New York can lead in that way. I don't know if others... I mean, this is I live my life playing with data. That's it.

Mr. Kraut Ms. Monroe.

Ms. Monroe Thank you for this.

Ms. Monroe I if I look at New York's population from a person's perspective, the fact that mental health, substance abuse organizations, all of these others are not looking at data the same way you're proposing that we do. I'm wondering if there's any dialogue to look at streamlining and bringing together, if not all regions. I used to work for state government in Illinois and the regions were the regions. Everything in Illinois was done by those regions. I'm not suggesting that, but certainly, you know, behavioral health, aging, health department all should be using the same regions it seems to me. Are you having any discussions about that?

Dr. Rosenberg The short answer is no. It's a very fair point. I mean, the thing is, you know, obviously, it's not an intellectually pleasing solution. We're starting with our DOH office structure, which is itself not necessarily compatible with the operating structures of the other agencies. It would need to be a big picture conversation around how we fundamentally organize the work. I think, you know, the mental health agencies do fundamentally have different regional structures.

Dr. Bauer I would just add, Ms. Monroe. We all start at the county level. With the proposal that we're putting on the table here we will still have our county level data. We're just looking at an intermediate aggregation to help us kind of streamline how we're presenting data. Mr. Kraut mentioned going below the county level down to the census tract or the zip code level, which absolutely we need to do, especially as we dive into the health equity work that the department is embracing. There are many needs for data presentation. I think what we're putting on the table here and we'd love your advice around is we've got county, we've got statewide, we've got our four regions. We really appreciated the granularity that the REDC regions provided us during COVID. As Dr. Rosenberg explained, they're not driven by our public health needs. We wanted to replace that with something else.

Dr. Soffel Can I just piggyback on that question?

Dr. Soffel I believe, and somebody correct me if I'm wrong, that the regions were based on the Medicaid rate setting regions that New York State uses. I think that the new waiver uses those regions as well as the basis for the social care networks. I want to sort of echo Ann's concern. How do we make sure that that one side of the Department of Health is talking to the other side, and that the way that OHIP organizes the state of New York is consistent with the way that you guys envision organizing the State of New York. I don't know which way is the better way to go, but I do know that there are reasons why they organize regions the way that they did. We are building public programs on those regions. I would love to know that these overlap.

Mr. Kraut That's a good question.

Mr. Kraut Is this schema going to be uniform beyond public health?

Dr. Soffel Related question.

Mr. Kraut Just within the department much less OMH, which is another good question. Is that the intent?

(Laughing)

Mr. Kraut Maybe you can't answer that. You may not be able to.

Dr. Bauer I mean, Eli presented on a short list, a subset of all of the different ways data is carved up and displayed. To your point, they meet specific needs. Had one set of needs. REDC has another set of needs. We showed the federal government's kind of health service areas, a third set of needs. Those cross even state borders. We're asking the question, what does public health need? We've been cobbling together. We've been borrowing these other frameworks.

Mr. Kraut This is the first-time public health is creating a framework that's unique for it, because you've been forced to use the other ones. Is that the issue?

Dr. Bauer We've largely used the four regions and working with our local health department partners, we came up with this.

Mr. Kraut Well, I think this is better than the other ones we've been using but go ahead.

Dr. Rosenberg I just wanted to just put out just to enhance the discussion. I presented before to this body on some of our dashboards that we have, particularly the one in support of the prevention agenda. We have a number of public health dashboards that use a common Tableau, which is the name of the system, sort of a common framework for showing information. That's sort of the way we might put out this new schema is to use those dashboards as a way to show regional trends. Right now, those dashboards do show information on different levels of aggregation. County is sort of the basic operating unit. There are areas that actually do go sub county, their zip code, for example. A number of the dashboards don't have census tract really built into that. I think it's a great idea. There's a lot of work to do to get to that point. That's sort of the way that you might see this as a user in the world is sort of interacting with our data dashboards.

Dr. Eisenstein Thank you.

Dr. Eisenstein This being to me in my prior role and currently as I launch an epidemiology program for a new hospital system the data is what drives public health. I agree with all of the comments that have happened. One challenge that I would just urge the Department of Health to consider is now that hospitals and health care providers in general are being asked lots of questions regarding the social determinants of health. There's a lot of different reporting that's required from different entities. They're all asking slightly different questions, which makes it very difficult. I was just preparing a presentation on what languages are spoken by our systems patients so that we could appropriately respond. It's an equity concern. If you look at New York State's data versus the census data versus what CMS asks us to report versus what Joint Commission asks us to report, versus what Leapfrog asks us to report. It's actually five different questions. Our electronic health record doesn't ask five different questions. It asks one. It needs to be tweaked for all of them. The point that I'm trying to make about the data is where possible, and I know that it's a job. It's a real difficult job. Where we could align it so that there's one very granular, locally focused database that can meet the needs. For example, an opportunity would be with the Medicaid waiver coming out. We don't know the formal parameters yet. We haven't heard yet. For example, we're hearing that we're going to need to use the New York State ACH tool. I have no objection to that, except we've already invested in using EPIC's tool to basically ask the same questions, slightly different wording.

Mr. Kraut We have the State Health Information Network, which we've...

Mr. Kraut Everybody turn off the mics because we're getting feedback.

Mr. Kraut It's the State Health Information Network that keeps a master patient index. That probably is a source of truth for so much of that. If we could standardize around that. I mean, look, standardization as much as it's challenging is a benefit when you're looking at health data. I mean, just so we know we're all saying the same thing and asking the same questions.

Dr. Boufford I wanted to kind of follow up on Ann's comment, which I think is this is really interesting. The problems of how local you can go are constant threads in the conversation about public health. A part of what you mentioned, Eli, I think, and this is really it's two levels of discussion. One of them has been coming out of the conversations around the prevention agenda. Whatever it ends up being. If there will be a collaborative, you know, some kind of local collaborative implementation process with a measurement or a metric sort of tracking area. Certainly, OMH, OASAS, DOH, and arguably NYSOFA have been sort of core partners there. The same core partnership is coming up in the Master Plan on Aging relative to doing things for people in communities or patients. I think OASAS has six regions. They've divided one into two parts. The Medicaid was mentioned earlier. NYSOFA has offices at the county level. I think it's a sort of extension of the question. One is collaborating on the data and the other is the implications for collaborating on implementation of sort of integrated interventions and sort of tracking how they work or don't work. It's an issue already and sort of fairly large. I'll take the Master Plan on Aging thing, because that's a ten-year plan. Other in addition to that Department of State, the REDC areas as well as AG and Markets, which I didn't bother. I looked everybody else up. I'm really delighted to have this matrix because it's much easier. I know this is probably a Governor's decision at some level, but I think it raises maybe having data in the areas you're suggesting doesn't prevent you from collaborating with your other sister agencies

who use different networks. That may be the case. I think, not having more conversations about sharing the data that came up in one of the Ad Hoc meetings, I think NYSOFA, and OMH and OASAS, you know, have begun to talk with each other, share data, etc. Not yet with the department. I wanted to just explore the data sharing and alignment. The other issue is the implications of data informing collaborative intervention, which is kind of crucial in forming the intervention and measuring progress with it. I don't know if I made it too confusing.

Dr. Bauer Just say that where we have made some changes. You saw the slide with the arrows and the flags and counties moving. That's because our local health department said, actually, we work together on the prevention agenda, or we work together on this plan with our mental health and substance use partners. We've made those shifts within the overall schema to try to accommodate that. We're wrestling with one now in the Hudson Valley, where there's a particular partnership among counties that they're eager to keep. That's the kind of feedback that we're eager to hear. We've heard aligning with Medicaid and the social need networks. We've heard looking below the county level in terms of census tract and zip code. We've heard collaborating with other state agencies. Can we all come up with something? I think one of your points, Dr. Boufford, is there's the data that go into what we display and how do we make sure that we're collaborating around the data collection, the data use, the informing decisions and so forth. I appreciate THAT.

Mr. Kraut Yes, Dr. Berliner.

Dr. Berliner Not to complicate further, but a lot of... None of the various permutations that you looked at mentions political boundaries of any sort. We heard this morning how a politician in a position of power from a particular area was able to influence spending. I think a lot of politicians would be interested in understanding the health dynamics and the other social dynamics within their districts. Those districts have been changing pretty much every year or very close to that. You have Assembly districts. You have Senate districts. You have other kinds of districts. I think it would be important for health data to also be aligned in some way with political districts.

Mr. Kraut I think there are two issues. One, I think what the department did and what you plan to do, I think it makes sense for you. It should make sense for us. It's rational and thoughtful. I think there's a bigger issue. It's Howards issue here. Let's put this on the list. I think we can come back and engage about the regular. It's not so much the regulating data. It's the organization and availability of data. Because there are there are statutory and regulatory requirements to do this the question is how it's organized. I would argue again, at the census track level it's just a matter of putting a library of definitions of how you want to look at the data and thinking. All of my community health data, I have it by political district. If a local senator wants to take a look at their community health data we use those maps. They change every couple of years. It automatically organizes all the data in the database that you're going to look at to produce a report that tells us about those issues. If you want to look at it at a local town or a city councilman district we do the same thing. It's because it's all organized at that census track level. If it's not available at census track because that's not always ideal, then we use an algorithm of 50% of the zip code is theirs. We use some GIS platform that does that. I think the power to require that not only for the DOH data, but for OMH and OASAS. That might be something that comes out of us that is a legislative proposal to give some rationale statewide. That's something we might want to come. It's beyond our authority, but we can do what's in our authority. We could try to advocate with the powers that be that this might make sense. I have to

believe, you know, all the commissioners if they were together would agree to have that available would be it a powerful tool for New York.

Dr. Boufford Just one quick comment. We're involved in a project in New York City now with using electronic health record data from the public hospitals. There's a lot of publicly available data from other agencies in New York City. We don't have to go ask permission for the others. Working with Microsoft Health and the use of AI in really analyzing this information and doing some of the things that humans would find very difficult, I think is an opportunity that really with the hundreds of millions, as you've said, that have been put into data systems respecting whatever confidentiality issues are. There's plenty of data that an AI approach if that capacity was built into the expertise. I'm sure it's somewhere in the state and obviously somewhere in the department can begin to answer some of these questions when needed. How do you bring it together from multiple agencies to focus on this geographically defined community?

Mr. Kraut I think it's good feedback for whatever hopefully you got out of it. God bless. I think the changes you made makes rational sense. I don't think we would argue. We look forward and hope. It's just helpful in moving forward in innovating and strengthening our health system. It's not a health care delivery system.

Dr. Rosenberg You said something really important under the hood of your last comments, which is I think what I'm taking away is actually the importance of flexibility in our system. There's never going to be one scheme that meets everyone's needs. There are political boundaries, different health care, you know, and so forth. In our tools that we make and we're making a lot of tools. We've upgraded a lot of our tools. There's a bunch more coming to build in the flexibility to re aggregate according to multiple schemes. That's something that could be made. Obviously, you know, rather than hard wiring this is the way. Obviously, for public health, we're going to have our preferred way. To be able to build in some more flexibility into those tools, I think important right there. As maps change, we can load in new ways to map.

Mr. Kraut You get the good engineer. You know, the CDC does everything at a census track level nationally. We just suck it up and we reuse it.

Mr. Kraut I thank you, Dr. Rosenberg, for sharing your experience. Sorry, we truncated a little, but the front end you really should read the slides. It's a real insight ball on census information and the challenges of getting a correct count in New York. It's very informative. We're going to take a break for lunch. Instead of taking an hour if everybody is okay, can we take like thirty-five minutes and then kind of comeback just to catch up a little on the day. We'll see how people feel about that after thirty minutes and then I'll ask you. I mean, we could bring our food in here if you'd like. It might be a little more. Let's take thirty minutes just to stretch our legs. Dessert and coffee in here. Eating in there. Let's be back about twenty after one, please. Thank you.

Mr. Kraut I think most of us are back in the room. I'm going to start by introducing the next topic that we're going to cover. I think one of the things that we've repeatedly had a lot of conversation about is a large part of our agenda, particularly in Establishment and Project Review is on long term care. And as you know, a lot of issues have been surrounding that particular sector of health care. What we've asked is for Mark Furnish, who directs the Center for Long Term Care, licensure, planning and finance to kind of come with us, go through some of the process issues. I think we want to focus the conversation on the

approach to it, character and competence review, the use of quality data, the public need methodology and the like.

Mr. Kraut Mark, I'll turn it over to you and then hopefully we'll engage in a fruitful conversation.

Mr. Kraut Thanks, Mark.

Mr. Furnish Thank you.

Mr. Furnish If we could go to the first slide and I'll go over what we're going to speak about. PHHPC has a very large role in doing all of this CON related work. Every cycle we go through, and we use terminology that I think we just take for granted. I want to take it and discuss it in further detail. The first thing I want to talk about is just the Certificate of Need to process and review for long term care facilities. I'm going to get into details about character and competence and the challenges surrounding that. Finally, talk about long term care, public need methodologies. There's a lot of dry gray area statutory language that I'm going to just discuss. That's just to set the ground rules. I'd really like this to be a discussion and have a set of problems that I want to bring up and discuss with all of you first. Before we do that, I need to go over what the statute says, and the regulation says. Bear with me on that. It's not a poem. It's very dry. Long term care, certificate of needs applications. Certificate of need is currently in thirty-five states. Fifteen states are like New York, where they have an independent body that grants the Certificate of Need. New York is not unique in that, although it's one of fifteen states that has this system. There are two types of Certificates of Need applications. There are establishment applications, which we all know is to grant someone the ability to get a license. It's the operator of allowing someone to get an operating certificate and is the final say in that. You approve or disapprove establishment applications. There are construction applications, which is everything other than establishment. Construction applications could mean hardhats, hammer, nails, building something. It could mean adding a service to your operating certificate or taking away. That's a construction application. Anything that's not establishment is construction. And in that instance, PHHPC recommends to the Commissioner, and the Commissioner has the final say granting that after it goes to the Public Health and Health Planning Council. There are three different types of CON applications. For the purposes of this discussion let's just assume we're talking establishment. This could apply to construction as well, but let's leave it to establishment. There are three different facility types that we bring to you. The first is an Article 28 residential health care facilities, which are nursing homes. The law differentiates. Sometimes it says nursing homes. Sometimes it says residential health care facilities. There are the Article 36 home care service agencies, which are the certified health home agencies and the licensed home care service agencies. Rarely, we see Article 40 hospice agencies. We'll discuss why that's rarely in this presentation. There's also a fourth type adult care facility licensure, which are ACF's that don't go to PHHPC. That's historical because the Department of Social Services was responsible for adult care facilities. They weren't considered health care facilities. When the Department of Social Services was removed as an agency adult care facility switched over to the Department of Health. That's Article 7 of the Social Services law, which doesn't speak about PHHPC or any of that. That's all done internally in house the acceptance. That's why you don't see any ACF's coming to you. You always hear me say when we do a Certificate of Need application, I say it meets public need, financial feasibility and character and competence. These are the three statutory prongs that must be reviewed before granting establishment or a construction CON. Public need was the original reason and justification for the CON laws,

which I will get into. Financial feasibility is the review of expenses, projected revenues, current financial status, and the capacity to retire debt. We look to make sure the applicant can meet the financial feasibility. Character and competence, which is based on experience and past performance in operating health care services, including record certain violations, if any. This is key. A substantially consistent high level of care was maintained. What does that mean? That's a good question. We'll get into that.

Mr. Furnish Next slide, please.

Mr. Furnish There are other factors that we are looking at. As you can see Certificate of Need have grown since 1966 when New York was the first state to actually have a Certificate of Ned law in place. In 1974, the federal government came in and said every state has to have a Certificate of Need law. That went till 1987. From 1974 to 1987 there was Certificate of Need requirements for each state. They got rid of that in 1987. Like I said, thirty-five states currently have CON laws. For those three prongs, public need, financial feasibility and character and competence we have added Health Equity Impact Assessments. We're facing that now. We've had several discussions about that. That is another thing that is now required to look at. This is the fourth prong, or I guess the fifth prong now. All other factors that PHHPC deems pertinent. That's a key provision that I don't think is discussed or utilized enough is that all other factors that PHHPC deem pertinent. That could mean almost anything, depending on if you have the justification for it. We've seen that recently with the licensed home care service agencies where you've asked us to look at workforce. That's an example of what you deem pertinent. Like I said, the CON requirements have evolved over time and are no longer just considered public need. Let's get into character and competence. We're going to do Article 28 nursing homes for this example. It could be any Article 28 under 2801A3. What is character and competence? A substantially consistent high level of care. Good question about what that means. About a few years ago, about two years ago, we added 2801- A3B, which is for nursing homes, which states a consistently high level of care getting rid of substantially, just saying consistently high level of care. There are questions of why we changed it. I think it's because we didn't want to get into semantics about someone saying, well, is it substantially consistent, high level of care as opposed to a consistently high level of care? Let's talk about a substantially consistent high level of care. That's for all Article 28's not just nursing homes. It's not found if there was a violation of the state hospital code or other applicable rules or regulations that threatened to directly affect the health, safety or welfare of any patient or resident. This is key. Was recurrent and not promptly corrected. That's for all Article 28. We use that standard when we look at nursing home CON's as well. 2081A3B which is designed for nursing home applications also requires review of each member listed on the application over the past seven years and for each facility and where they had a controlling interest or where the controlling person. We look at that.

Mr. Holt Just remind us of what threshold of ownership they have to achieve to have an interest where they're subject to review.

Mr. Furnish Ten years and then seven years for the controlling interest.

Mr. Holt But percentage of ownership.

Mr. Furnish Oh, that's the CMS litmus test. We'll talk about that in a few slides.

Mr. Furnish The applicant on a C&C requirements, which is Schedule II of the CON was any facility that has earned a two star or less CMS rating, any violation of state or federal

rules and regulations that deal with residents safety like immediate jeopardy or actual harm that were current and not properly corrected over a three year period, any facility that's been in receivership, any facility closed result of a settlement agreement from decertification or license revocation, and an involuntary termination for Medicaid or Medicare in the prior five years. The applicant has to disclose that. Now, it's important to note it's the role of PHHPC, which is all of you, to determine whether the substantially consistent high level of care threshold was met. They have to disclose those things I just outlined. It's up to you to determine whether or not a substantially consistent high level of care was not met. That's all the statute says. What about the regulations? That outlines it in greater detail the statutory framework. As I just indicated, PHHPC decides whether consistently high level of care has been rendered after evaluating the gravity of any violation the way the applicant, an operator, exercised supervisory responsibility over the facility operation and the remedial action, if any, taken after the violation was discovered. The percentage of nursing homes in a portfolio with a two star or less rating. I will get into that in greater detail. In evaluating the gravity of the violation that PHHPC to look at, you shall consider whether the violation threatens or resulted in a direct significant harm to the health, safety or welfare of patients and residents, and the manner in which the applicant or operator exercised supervisory responsibility over the facility. Operation typically shall consider whether a reasonably prudent individual of the applicant operator should have been aware of the conditions which resulted in the violation, and whether the individual of the applicant owner was notified about the conditions in which resulted in the violation. You look at the gravity of the situation and the steps taken to correct it. You weigh that and you determine if a consistently high level of care was met. And then in evaluating any remedial action taken, PHHPC shall consider whether the applicant operator investigated the circumstances surrounding the violation and took steps that a reasonably prudent applicant operator would take to prevent the reoccurrence of the violation. You're seeing a trend here where it's a balancing test, where you, as a body have to make the determination when we bring something to you and it's cloudy on whether or not they should make it. You have to take the balancing test. What the gravity of the situation was? Was it recurrent? What steps were taken to rectify it? In evaluating instances of a facility affiliated with an applicant operator earning a two star less rating PHHPC shall determine the percentage of nursing homes in the portfolio that each individual of the applicant operator has held an ownership interest for forty-eight months or more and has earned a CMS star rating of two stars or less, which is a CMS litmus test, which we'll discuss in a little while. When any of the following moves occurred in the prior five years, there shall not be a determination of a consistently high level of care. These are the automatic bars; closure of a facility or facility as closed a result of a settlement agreement from decertification action or licensure revocation, a health care related facility agency program was subject to decertified action or license revocation, and an involuntary termination of a health care related facility agency program for Medicare or Medicaid. If the applicant has any of these, then they're automatically barred. It would never get to because we would either not bring it to you until they found a new ownership structure, or we bring it to you for disapproval. Violations found, whether threatened to directly or affect patient residence, health, safety, welfare, or resulted in direct significant harm to the health, safety and welfare of patients were recurrent are not promptly corrected. Now, that for a long time in long term care facilities, the question was what does recurrent mean?

Mr. Furnish What does recurrent mean under the new section of laws? A violation is recurrent if it has the same root cause as a violation previously cited within the last seven years. A violation is not promptly corrected. If a plan of correction has been submitted the department within ten calendar days of the issuance of a statement of deficiency. The facility has failed to provide an acceptable data compliance based on the violations.

Recurrent means the same root cause of violation within the last seven years and promptly corrected is ten days from the date of the notice of deficiency. They have to have a plan of correction. That was the clarification we just recently developed. There's also something now called the CMS Litmus Test, which is when an individual or an applicant operator has greater than 40% of the nursing homes in their portfolio with a CMS star rating of two stars or less and has had an ownership interest in such nursing home for forty-eight months or more. There shall not be determination of a consistent high level of care unless the portfolio contains fewer than five facilities. PHHPC shall make the determination on a case-by-case basis. If you have 40% or more of nursing homes in your portfolio with a two star or less and you've had them for forty-eight months or more and you have more than five facilities you're automatically barred. Say you have four or less of two star or less then it goes to you for your determination on a case-by-case basis. That's why I went through all this. You got to look if its recurrent, root causes, steps taken to correct it, length of ownership, all of that is in your hands to decide. Now, that we've gone over that some questions that you should consider when doing this. What is the same root cause? That's hard to define. Is it just the same survey tag or the exact same set of circumstances? What is the root cause mean? How does this body want to define what root cause means? How do you determine if it's promptly corrected? Yes, we now say ten days from the date of a statement of deficiencies. You have to have your plan of correction in. How well does the plan of correction does it satisfy the problem? Does it go to the root cause? Again, what is the root cause? These are all questions. It's up to you to determine. Here's some questions that are always problematic and that I think is worthy of discussions. How should PHHPC as a body handle the following applications that include individuals without existing nursing home ownership? You've got a new group of people coming in. They say they're an administrator at a nursing home. They have experience in the health care field, but they don't have operational experience in a nursing home right now. The policy of the Department of Health is that you have to have at least five years or more in a health-related field for nursing homes to do it. Should it be less? Should it be more? The law is not clear on that. How do you determine character and competence as someone who doesn't have a history and background, but has the financial capability and public need is met? That's one example of the things we always run into. Applications where an individual who does not pass character and confidence, then it's modifying the application to replace themselves with a family member or associate. We see this all the time. You've got John or Sue Smith. No way they’re going to make character and competence. They say, all right, I'll replace it with my son who has experience and does not have the same kind of taint or confusion that John Smith has. Should we look at family relations or not? Now, the law is silent on that. Should the sins of the Father or the mother be put to the son or the daughter or the cousin twice removed or the best friend that has a clean record on paper if you don't associate them with the taint of the person that's the problem. That's a concern that we always have. Other questions to consider. Out of state ownership. New York has what's called a corporate ban on the practice of medicine, which means that natural persons have to be reviewed for character and competence. Homes owned as a trust, multi-level LLCs and many private equities cannot be considered proper structures for character and competence purposes. You have many nursing homes in the state that are close to closing or are about to close. We need new capital to come into the state to invest in nursing homes. They can't because of the natural person bar. How do we handle that? How should we handle that? That's a question that's going to come up more and more. Another question is individuals who meet all the character and competence requirements for approval, but their overall portfolio is still not ideal with a number of low rated facilities. This is what we see all the time, right? You say I bring something to you. It passes the statutory recall, the statutory hurdles to get to you for an approval. There's nothing to automatically bar them from approval. It's up to you, especially since you have

the final say and you've got the other factors you deem pertinent, but their star rating is less than ideal, maybe twos, maybe all ones. There's nothing that triggers an automatic bar. How do you deal with those? What should the standard be? Are you going to be consistent across the board on that? With such a limited pool of individuals associated with nursing home ownership it can be a challenge to move projects forward with quality individuals. We're running into this problem where out of state, because of the corporate practice of medicine makes it very difficult to have new investment opportunities to come in. We've got a limited amount of qualified applicants that can move forward. We don't want to encourage family members to come in who are closely associated with the person that's tainted. You've got a nursing home that's about to close with a limited financial short runway and that can only last a few more months. What do we do in those situations? Those are questions that come up constantly and something worthy of discussion. We can talk to those in detail. I do want to go over public need methodology quickly too. The first prong is public need methodology and one of the prongs necessary for CON review. Here are questions that we need to ask ourselves. What defines public need and long-term care? How do we determine it? Why is it important in 2024? Public need history. Back in late 50's, early 60's it started. Milton Romer, who was a UCLA School of Public Health Professor came up with a theory that there's a high correlation between the available number of hospital beds and those that use beds. You build it they will come type of situation. J Enoch Powell, the Minister of health in Great Britain in 1964 was also a big advocate of what he called the Parkinson's Law of hospital beds, which states the number of patients always tends to equalize with the number of beds available to lie in. He was kind of a mean-spirited person to say the least. That theory, those two theories really started to gel with the consensus. Because during that time health care construction was getting bigger and bigger. In 1966, New York followed the trend first by developing the first Certificate of Need law. And then, like I said, by 1974, Congress required all states to do it. By 1987 advances in legal systems and things like that it made them reconsider whether it should be a mandatory CON related thing. That's where some states got rid of their public need. That's the history of why public need started. It was originally designed to prevent the massive glorification of building facilities. You're going to have a bed you're going to have to fill it. What is public need? People always confuse public need with public need methodology. The statute only requires that public need be made by PHHPC. That's all it says is that PHHPC's got to say that there's public need. The public need is met. It's the regulations that determine through a public need methodology if public need is met. Historically, New York has had these complicated need methodologies in regulation to determine need. Now, we've saw an exception to that recently with the licensed home care service agencies, where we said, how do we determine need? We broke it down into counties that had five or more and those who didn't have five or more. Those that didn't have five or more, we determined those counties had need. Those that did have five or more didn't have need. That was the need determination. It met that in statute. It's simple. There's a rebuttable presumption for those counties that don't have need like the big. Like say, Monroe County doesn't have. It's on the no need list. However, if someone could come and say, look, there's special health equity concerns, religious special needs, things like that that the department could consider waiving the need. We have that. That's a form of a need methodology, but it's not a complicated need methodology. Let's look at long term care health need methodologies by facility type. We've got the Article 28 nursing home needs should be updated every five years. Unfortunately, the last update for nursing homes was in 2016. That's because of COVID. That's a complicated need methodology that we're working on updating as we speak. Article 40 hospice agencies has been outdated for well over fifteen years, probably more, and relies on outdated cancer statistics that have changed because cancer outcomes have changed dramatically. The way we treat terminal illness has changed. To determine need based on outdated cancer statistics

doesn't make any sense. A certified health home agency has an outdated need methodology. That's been around for over a decade as well. In fact, this body had to pass emergency regulations during one of the regulatory modernizations acts to waive the public need and to allow for a... Because the outdated need methodology and allowed for request for applications for a certain time limited number of times. That's a way we can get around need methodology too. It took a special emergency regulation. It came to PHHPC at the time, I think it was 2015 or so that you had to waive the need methodology for that. The Article 36, which I said is the counties with five or more is no need for counties with five or less equals need.

Mr. Holt Mark, before we leave this page, absent is the program assisted living Medicaid program. Where will that factor into this discussion from a need basis? I mean, there's a very distribution across the state in terms of where the beds are located. My own personal belief is that in those counties where there's a significant number of beds it's had an impact on what's happening on occupancy. As you're going through the discussions about how these need to be updated, I want to make sure that that gets in the discussion.

Mr. Furnish Sure. I tell you right now that that is due next year and we're actively starting to work on that need methodology, which I didn't bring up here only because PHHPC doesn't have a purview of that, but that is a very real. It's a big, interest to the department and to the shareholders as well.

Mr. Furnish What are the consequences of an outdated need methodology? They become unworkable and create de facto moratoriums on new CON, which we've seen with hospice and CHHA's where we can't allow new CON applications to be accepted because we can't get past an outdated need methodology, so they can't get through the first prong of the public need. The current nursing home need methodology is found in 709.3 and establishes the criteria and initially that nursing home need methodology was implemented to determine appropriate and efficient allocation of capacity within the long-term care system, promoting access and financial sustainability. In 2016, they revised the Hospice Need Methodology to ensure access to appropriate and available long term care settings. Estimating the need, the supply of all provider types, institutional and community based was considered but allowed for some flexibility, which I call escape hatches to consider local factors, including special needs of a facility's population and quality of nursing homes in the planning area and allow responsiveness to the changing environment. At the time, we made the big deal of saying that the need mythology was designed to function as a guideline. It's not meant to be an absolute predictor of the number of beds needed in each planning area. We knew from the beginning that the methodology was going to be effective for just a short duration. At the time it was let's see it plays out. I don't know how that played out so much because of COVID and things of that nature as well. We do have to change that and it's due... It's overdue. We're going to be working on that. Need criteria is not in a vacuum. Remember there may be need, but the factors like character and competence and finances may prevent a CON from being approved. Many different factors go into considering an approvable CON. Just like with the character and competence here some factors we need to consider. What does public need mean? Are complex public need methodologies necessary in 2024 and beyond? Some argue that market forces should drive the need and not and not a set determination. That's something that it's going to have to be discussed. A lot of people do bring that up. How frequently should we reassess and revise need methodologies? What data should the state consider when updating a need methodology? Should we look at workforce quality indicators? What else should we look at? Need methodology should function as a guideline and are not meant to be absolute predictors of the number of beds needed in a planning area. What should the

occupancy rate threshold be? Right now, 97% is the magic number for new beds. Is that something we should continue to hold on to? What should the planning areas consist of? Counties? Regional planning areas? What local factors; public transit, geography, weather patterns, workforce? Those are the two issues in the problems that we see related to the CONs. It's squarely within your purview to discuss these and answer these questions. I'll open it up to questions or comments.

Mr. Kraut Thank you. First of all, that's probably one of the most thorough examples/explanations that I think we have about the process and the issues. You touched on a lot of the complexity because some of this sits in a gray area, right? I think that's the things that we've struggled with.

Mr. Kraut Let's get the questions on the floor and then see how we can kind of systematically go through.

Mr. Kraut Mr. Robinson.

Mr. Robinson Mark, that was a great presentation. Thank you very much. I think that the need methodology questions around long term care, and therefore, the viable options for either opening new nursing homes or transferring ownership as appropriate. I will say that we kind of are in a little bit of a limbo. This may only apply more to Upstate than to the city. I don't know that for a fact. At the moment, for example, in in our region we have close to a thousand approved but unstaffed nursing home beds that are not open. Obviously, a lot of that is doing is due to staffing and the affordability of staffing given the fact that most nursing homes are operating at a margin. When you look at need methodology the first thing you have to look at, I think is what's going on with the existing capacity and inventory. I think we have to figure out strategies for addressing that. That may actually mitigate some of the additional need that might or might not be there. That's one point. I think the other point that kind of is a little frustrating is the... Frankly, the proprietary nursing home side of things. The economic incentives that are in place, I think there is across health care, but especially in long term care. This belief that we need capital and the only place to get this capital is from the private sector. The reality is that money even if it comes is not free, because those people who make those capital investments are looking for a return on investment. Oh, by the way, where does that return come from? Who pays for it? Well, it comes out of the nursing home operations, which either drives payment rates higher in order to cover those costs. We're paying for it anyway. The public is paying for it really, because the majority of this is in the Medicaid sector. I do think that the other thing we really do need to look at strategically is how we bring capital into this sector, not assuming that it has too necessarily be proprietary. In the end, if it is the state that actually has to sort of make those capital investments it may be a more efficient investment than if it comes from the private sector. I think some broader conversations at that level. Obviously, that's a policy question for the Governor and the health department to address. I think some of these pretzels that we kind of make of ourselves as we try to solve the regulatory requirements for the existing process kind of put us well beyond the place where first policy is to be introduced and or funding has to be introduced in a different way. Just my observation.

Mr. Kraut Let me go to Dr. Boufford and I'll go down the table.

Dr. Boufford Thanks for this, Mark. It's really unpacking a lot. One of the things we talked about, I guess it was at the last retreat. Was this idea of a strategic approach to long term care, regardless of venue or type and model. We haven't had that. I think one of the things

that's coming up repeatedly in the Master Plan on Aging is this mantra that people would prefer to stay at home as long as they can. I think in some ways if that side of the universe is sort of saying this ought to be the guidepost to thinking seriously about that as far as long term care services acceptability to the public is concerned to older people is we really need to focus more on the CHHAs and the LHCSAs and whatever else may be going on relative to things like the level of technology that's possible at home, the reimbursement of informal caregivers. This whole space, it seems to me is something we haven't really gotten into. On the one side, we're getting policy recommendations that people want to stay at home as long as they can. The other side, we've been focusing more on the built environment, if you will. You know, the bricks and mortar part. That's sort of one thing. Just in terms of our own thinking going forward maybe you can react and help us think about sort of respond to that part of the equation. If there are people wanting to do more interesting, innovative, sophisticated things outside of nursing homes that aren't able to because of lack of regulation or too much regulation or something. The only other thing I'd say is I go to every time there's a conference on social and impact investing. The Federal Reserve in New York has been doing a lot of work here. There are a lot of organizations and others that do this. The bottom line is there's got to be a third-party funding stream for private capital to come in. That's governmental third-party funding stream. It's Medicaid. It's Medicare. It's whatever you're going to get. Otherwise, the return on investment is too low for most people. Some will do 3% over five years. Most won't. A lot of them are looking for the old 11% return out of something like this. You're getting a lot of more investment in community health centers and residential facility. Things that people really can be sure they're going to get their money back over a period of time. I think that your point is an important one. The reality testing of degree to which it would need to be some kind of joint investment with government plus the reimbursement system for finances is probably very, very, very valid, I think. Just get your reaction on the non-bricks and mortar.

Mr. Furnish Sure. Your first point you're absolutely correct. That's something that when I said need methodology shouldn't be done in a vacuum. We can't change the nursing home need methodology without looking at home care. We can't look at that without looking at hospice. The discussions that I've had with members of the department and other places have said that, that we can't look at that in a vacuum. What worked ten years ago was not going to work today in terms of health care, home care services are needed. I agree with you 100%. That's something that we are looking at and taking into account.

Mr. Robinson Yes, Ms. Monroe.

Ms. Monroe Thank you very much, Mark. This is something I've been looking forward to. I've been in the room when we have approved some nursing home applications where I think we're all gritting our teeth. What I don't know and would be helpful is to understand what happens after we approve something in the sense that if quality goes downhill. Are you in the department looking at pulling a CON? What consequences are there if we guess wrong in our approval? I mean, I recall one where the administrator his experience had been he worked in a carpet store. We approved him as an administrator, but I never heard anything after that. Whether he was able to run this facility in a great way. What is the consequence of not having addressed these need methodologies or approving things that we might have had serious doubt about?

Mr. Furnish I'm sure I could start by saying what happens in a normal plain vanilla time when you grant approval. Once all the contingencies are done, it goes to the regional office of the department for a pre-opening survey inspection. If that passes that, then the operating certificate to run the facility occurs. Now, in terms of the establishment of

PHHPC's role in this. If we catch someone lying on an establishment application and I came to you and presented something to you that turned out to be a lie that they lied about, then there's provisions within the statute that says that we can bring it back to PHHPC so you can pull their establishment.

Ms. Monroe Has it ever happened?

Mr. Furnish Not in my time.

(Laughing)

Mr. Furnish Now, in terms of quality that's what the survey process is. If they find deficiencies on survey, then they have to file a notice of correction and go through that whole process. They have all those appeal rights and things. Again, if it gets so bad, then there's a thing called a license revocation, which takes a long time, but that would not be PHHPC controlled. That would be department controlled. If we catch them lying on establish a revocation there is an avenue for PHHPC to pull back an establishment. Otherwise, it goes through the department recourses.

Mr. Kraut Ms. Soto.

Ms. Ngwashi Can I just finish?

Mr. Kraut Sure.

Ms. Ngwashi I was just going to clarify that revoking someone's license once they have it is an incredibly difficult thing to do. Not only do they have due process rights that have to go through the standards are really, really high. The facility has to be financially unstable or there has to be risk to life. It's a very, very hard thing to do, which is why so much consideration needs to go in on the front end. Otherwise, it becomes very difficult, and it winds up being repeat surveys and use of department personnel in order to stabilize the facility.

Mr. Kraut Let's get some questions and let's come back to the front-end character and competence.

Dr. Soffel I've had a question so many times about the difference between the owner and the person who is brought in to actually operate the facility. Character and competence only speak to the owner. What if the owner says, I am hiring Ann Monroe who's got fifty years of sterling experience running a nursing facility and she's going to be actually responsible for operation. Is that something that we are able to consider in evaluating an application?

Mr. Furnish You can and that could be a fourth factor, right? All things you deem pertinent. However, and this is something that we're I'm looking at Cathy and Margaret right now because this is something we're dealing with now. There's a thing called an illegal delegation of authority that says that only the person that gets established is on the hook for all the key things like the books, the clinical decisions, the major hiring and firings. Some people may play a little fast and loose with that. That's something we're starting to look at closely. They would never say that. If they said that I'm going to give up my delegation to you then I would recommend disapproval, but they wouldn't say that.

Dr. Soffel You're saying that, in fact, the owner has the ultimate responsibility. Even if they point to a crackerjack operating expert that that doesn't change that they are the party of responsibility?

Mr. Furnish Correct. You know, there's something to be said for allowing a management company to come in. The department always looks for someone to be on the hook and that's the established operator, and that's who we go after.

Ms. Ngwashi If I may, let me just add a couple of things here so that we can gain some clarity about this. Because the terminology is very important here. I know you're saying owner and then operator. They're the same for us. We have established operator. That's the terminology that we have in statute. That's what we use. We don't make a distinction between owner and operator. They're not two different things. It's one. An owner of the real property is different from the operator of the actual facility that gets the license to operate the facility. I understand that, but I think you might be talking about an administrator, right? You might be talking about somebody that's coming in as a consulting entity. That's why I'm saying the terminology matters. Because when we talk about owner or operator of a facility that's the same thing. Sometimes they bring in an outside entity or an outside organization or an outside individual to manage the entity that is seeking to become established. Again, I know it's starting to get to be a lot of terminology here, but it's important to understand the distinction. We understand exactly what we're talking about.

Dr. Soffel Would we consider that as part of our consideration?

Ms. Ngwashi Yes, whenever something like that is presented in an application that we are considering. We do consider it when we are reviewing the project application before it gets to you.

Ms. Ngwashi The caution I would raise to that is an administrator is an employee of the owner. The administrator that is there when the when the CON is approved could be gone in a year.

Mr. Kraut Could I just ask a clarification?

Mr. Kraut We have an ownership group. There are five people. Are they equal in accountability? Because sometimes we ask who's the managing partner. Do they have equal responsibility and will be held equally responsible for the operations as joint owners, regardless of their percentage ownership?

Mr. Furnish They're all established? They would all be the same.

Mr. Kraut How do you determine the competence of an owner who's 18 years old, a student at school? How do you bring and say to us that that person has the competence to be an owner of a nursing home to be held accountable for the actions? I'll stop there.

Ms. Ngwashi I think that I don't want us to speak for things that have happened in the past, but I think that the point of what Mark is presenting today is to be able to start this dialogue with you about the CON review process, particularly as it relates.

Mr. Kraut We could come back and say there are certain criteria's that owners must perceive. We could say they have to have ten years of business experience. We could make any criteria.

Ms. Ngwashi I think that the importance of the fourth prong in statute, which is any other factor that PHHPC deems pertinent is going to be relevant here when you want to bring something like that up. I think it needs to be made in the context of that subject application. When you see the level of experience that is put before you, you can make a determination about whether or not you think that is sufficient for that person to become either the member of that entity or the operator.

Mr. Kraut We can approve four of the people and decline one of them if we feel that that's the case?

Ms. Ngwashi Yes.

Mr. Kraut That CON would have to be withdrawn and resubmitted because we need to know the ownership.

Ms. Ngwashi They might not withdraw it. They might just amend it.

Mr. Furnish We'd have to look at the financials and things like that.

Mr. Kraut It's a little thread you start pulling. You're saying we can come back and create any of those criteria.

Ms. Soto My question is similar in all of this. On Slide 18, it said that the application we may learn that the application was modified, and the person was replaced with a family member or an associate. My question is how would we, PHHPC know that that occurred? Is that information we will be supplied with that an individual has been replaced with a family member or an associate? That's my first question. My second question is in terms of the long-term needs methodology on 24 and you're pointing out that things haven't been updated in fifteen years and 2016 and so forth. Whose responsibility is to update these methodologies? That's my second question. My first question is will we as PHHPC, learn if someone has been substituted as a possible family member or an associate? Two, whose responsibilities is to update the methodologies?

Mr. Furnish The first question all CONs are a matter of public record. If someone comes in with a CON, they modify and change it, it becomes a matter of public record. You can see who they substituted with. That would be known. In terms of who who's in charge of the regulations it would be the department who drafts the regulations and determines the methodologies.

Mr. Kraut I'm going to go around the table.

Mr. La Rue I got several comments to make.

Mr. Kraut Please go ahead.

Mr. La Rue I'm going to start with private equity two things. First of all, across the country for those folks who pay attention to what's happening in this industry. Many of the nursing homes across the country were purchased by private equity. They sold the land, took the

profits from the land and then leased the land back to the nursing homes at rates the nursing homes couldn't afford. The majority of those chains have gone bankrupt. They walked away with the equity that was in the program. Here more locally in New York, my concern with private equity is the inadequacy of the Medicaid rate, which creates an unbalance in the demand for certain types of patients. The only way that a nursing home can survive from a payer mix perspective is to have Medicare business in your home. You've got to have sufficient Medicare business to offset the losses that you suffer on the Medicaid side. If you have private equity coming into the marketplace they're going to build nice new, brand-new facilities, which is terrific. We need them. They're going to take all the Medicare business, which is going to have the undesired effect of creating lack of access, inequality and a lack of equity for the people who are on Medicaid and have behaviors, substance abuse issues, all the things that make it challenging to care for those patients aren't going to have a place to go. I think there's a lot of ramifications to private equity that need to be really thought through in terms of what the consequences are. In terms of Dr. Boufford's comment about the institution versus community-based services. I can't agree with that more. Everyone prefers to be in the community with the people they love, the communities they grew up in. We need to expand those home and community-based programs. At the same time, there's the silver tsunami taking place. Over 10,000 people a day are turning 65. The average age is accelerating. The demand for institutional care is not going to decline because the population, the percent of that total population is on a greater end. You're still going to need these institutional care services, even though a smaller percent of the population in total will be in those institutions. I personally believe that the institutions are going to be focused on two populations going forward. Extraordinarily very high clinically complex people who used to be in the hospital and no longer in the hospital. They're being treated in the nursing home. The second is memory care. It's going to be individuals with dementia and memory care that are going to require the institutionalization. It's important to stay focused on the change in the population, which New York is doing through its Master Plan for Aging, etcetera, and the demands that are going to be there in terms of the services. I wanted to mention the financial feasibility because after the last meeting or two meetings ago I'm not sure what the threshold is. Is the financial feasibility supposed to be that that individual program or nursing home as an example, can support itself? Is it okay that the nursing home can't support itself, but if the owners say that they're going to put equity into it and let it operate at a loss that that meets financial feasibility? That was one question. In terms of character and competency, I think this group has done a tremendous job. I think I've been on this council eight years. The difference between what was being approved eight years ago or nine years ago and today is significantly different. We've put all kinds of criteria in place that Mark went through that has really impacted the ability of a CON to get approved. In fact, I get concerned. Maybe there's been five since before the pandemic nursing home applications that have actually made it through PHHPC and been approved. It's a very small number. That's because the majority of the individuals who want to buy nursing homes don't meet the criteria. That's a good thing that we're weeding out those individuals who don't meet those criteria. As Mark pointed out, you now end up with a situation with the nursing home going to close. We don't have anyone to operate it. How are we going to handle that? What are we going to do? I don't think the default should be let's put a poor-quality operator in there because we don't have anyone else to operate the facility. Character and competence are a very complicated matter. Everyone would like a checklist that said that if they did this, they did this, they did this. Boom. They could be an operator. It's just never going to be that simple. There isn't any operator that isn't going to have a negative outcome happen at some point in one of their homes. To me, the key is identifying a pattern of poor behavior. If you own ten nursing homes and eight of them are one star that's not an untoward set level event. That's a business practice. You're operating your homes intentionally at a one star. Those

are the folks that you want to try to weed out. Those were my comments and only the one question about financial feasibility.

Dr. Kalkut I had a question related to Jeff's. He used an example of an owner who was a student that was several months ago. There are other examples of people with no experience, skill set or education that has anything to do with ownership in a nursing home. I don't see how we can evaluate competency in a student or someone who has no experience, but we approved those owners. You would mention, could we if there's five owners take out one. I would certainly support that. The idea that there is no experience or nothing else that suggests competency. Can we exclude that person from the ownership if we can't evaluate competency unless I'm missing some element that would allow one.

Mr. Furnish I just want to get the pattern straight. You're saying that someone with zero experience but is with a group of investors who do have the experience and is part of that group.

Dr. Kalkut Right or the student who was, it might even have been a relation, member of the family. Absolutely nothing to suggest competence.

Mr. Furnish As a PHHPC member, you have the right to say we were not going to accept it with this person on here using the fourth prong. I don't think character and competence would work because of what I outlined all the things that you need to look at and what are automatic bars.

Mr. Kraut Could I ask you, when you get the information about the owners. They file paperwork. It's an application. If they've never owned a nursing home or they're new. Does somebody physically sit with them and interview them? Does somebody meet with somebody to see what their competencies it?

Mr. Furnish We have a unit that does that where we send questions and ask them questions and things like that. There's no sit down and formal interview.

Mr. Kraut Is there anything in our regulations that say if we are doing establishment we will only consider the application if every member of the ownership group comes before us so we can do that. Are we permitted? Would that be a reasonable request?

Mr. Furnish I do want to make clear, though, that we're not allowing people with no experience just to take over. They're part of an investment group.

Mr. Kraut I'm picking up on Gary's point is, let's say we have an establishment project review. There are four people different backgrounds. We say, come into this room. We have questions. We'd like to see you. We'd like to meet you. We'd like to talk to you and determine. If you had somebody in the room here and we start interviewing somebody. Say, well, have you ever operated a nursing home? If we started asking questions to see if we're satisfied. Is that something we were able to do? Because we require it of applicants of any other application to appear here. Why wouldn't we ask the owners of a nursing home to come as a group, not just one person, but we get to see everybody. We know exactly who we're approving. I'm asking you.

Ms. Ngwashi You can ask all of them to come to the meeting, particularly to EPRC, so that you can, have a conversation with them. I think that what we're hearing today is very informative and instructive for us, particularly in legal for when we are looking at the project

applications and having conversations with not just the applicants, but their consultants and their counsel, but more particularly the actual applicants.

Ms. Ngwashi I want to flag back. Remember, the standard is going to be substantial evidence to support a decision. Depending on what the ownership group looks like, what the ownership percentage is, what their experience is. You'll have to take all those factors into account and what evidence you have in reaching your decision.

Mr. Kraut I understand. You said to me before they're each held individually, not collectively responsible. I could look at each one of them individually to make that substantive decision. I don't have to look at them collectively. Is that correct?

Ms. Ngwashi Well, you kind of have a controlling.

Mr. Kraut That gets back to the other question. We identify who the controlling partner is, so the others are not held accountable. I mean, this is the issue. I have a secondary issue. You don't even know from the websites of many nursing homes who the owners are. I mean, there's a disclosure issue. I'd love to make a requirement separate and apart on how to contact the nursing homes, the names. I've seen them both on proprietary and voluntary, not listing the boards. I guess the point is, do we then just really concern ourselves with the controlling or the majority interest or we don't? You know, I'm not looking to make an unreasonable demand because you heard Peter say, we have a thousand beds that are not open. We need this capacity. We just need it to be run at a standard that's acceptable to the people we're entrusted to make sure their responsibility.

Mr. Kraut Go ahead.

Mr. La Rue I'm getting confused between ownership and operatorship. It's my understanding that in order to run a nursing home, in order to be the administrator, you have to be licensed.

Mr. Kraut Yes, but that's not ownership.

Mr. La Rue Right.

Mr. La Rue My question is, if I own a Tesla plant.

(Laughing)

Mr. Kraut Get me the truck.

Mr. La Rue Why do you care as long I haven't been accused of fraud and anything, but I'm going to hire someone who's licensed by the state to run the facility.

Mr. Kraut I agree with that. I look at it as the model as there's a board. The owners are the board of trustees. I'm assuming this board meetings. They have review of quality information. There isn't accountability. Who's accountable to the public? Is it the licensed administrator or is it the ownership group, which is let's not call them the ownership group. They're the board of the facility.

Mr. Furnish It's the established operators. The people who went to PHHPC and got established and whose name is on the operating certificate are ultimately responsible.

Mr. Kraut I don't want to overly peel the onion here, but I think this is an issue that needs to get on a conversation to take a look at some of our regulations and operating procedures and not make them unduly too high that we can't get anybody approved. That's not going to serve us well. It's just the concern that we are getting people approved that are going to pay attention and be accountable. You want as many four star and five-star operators as we can to be approved in the State of New York. That's really your objective. I mean, if you have to think about it in that way.

Dr. Lim I have a different question. It would help for me to have some a little more clarification or guidance about for those situations where there isn't substantial evidence and maybe more along the lines of quality. Let's say it's a new operator owner coming into New York. They have a history of where their quality measures are not so great out of state. There isn't substantial evidence to say no if we take into consideration all the domains or all the prongs. What are the types of, I guess, contingencies or recommendations that PHHPC could provide in order to help sort of like, for example, I don't even know if this is appropriate. Is there like a probationary period? Is there a period of more frequent surveying? That would just be helpful to understand so that even if we approve it and if there's some level of concern. Is there something else that we can do to sort of help make us feel more secure if that's even an option?

Mr. Furnish Yes, I've seen it done several times where PHHPC will on the record at the meeting make a contingency saying quality has to be done. Reports have to be done within X amount of time as a condition of the license. It puts a limit on the license. We could pull it if they don't make that certain condition. There are contingencies that happen before the approval.

Mr. Kraut This is just following the thinking about that we have some concerns about the group and whatever fashion those concerns are. We can attach a condition that basically says return to us in X time with evidence that you have successfully did what you said you were going to do. It's almost like putting a monitor on. It's self-reporting really to us. There's a loop back. Ms. Monroe was talking about that with other projects that we would have a follow up list to say this was done. We had this condition. We'd like a report back. We calendar it for a meeting a year/two years from now. That might be a way to deal with concerns. I'm very mindful of what Mr. La Rue said.

Ms. Ngwashi Contingencies or condition.

Mr. Kraut You'd still allow the certificate to go through because you don't want to hold them up. You just want to get some feedback that your concern whatever was raised could be addressed at a later date. You could decide how do you deal with that.

Dr. Kalkut Can I just return back to the having the ownership when the project comes to the EPRC? Is that something we can do?

Dr. Soffel This is not in the spirit of the earlier conversation about. We need to do what we should be doing before we do stuff. We are doing it. I just want to flag it here. At one point, when we had had the earlier conversation about strategic planning for long term care we had talked about it. I see the health equity indexes listed as in the under and also for number four category, which as it should be applied. We had talked about similarly looking at linking something to if not the prevention agenda, age friendly. I mean, there are standards that could be developed. I just want to put that back on the table, because we

had had a discussion about it at the last retreat. I think there are certainly global standards, national standards that could be applied with the idea of opening the walls, making community members, you know, people that are living there and more able to go out, people who are able to come in. I mean, things that maybe restricted at this point in time that could be thought about. I just want to put that back on the table for a future conversation.

Mr. Kraut Honestly, there's different newer models of nursing homes that maybe the regulations don't necessarily support kind of grouping individuals and different floor configurations. That's kind of in that category to come back.

Mr. Kraut Mark, thank you very much for what was a very thorough and informative conversation. That was probably the best compendium I've seen of nursing home regulations and stuff like that. Thank you very much.

Mr. Kraut We're now going to turn, to Ms. Glock, who is going to lead us in a conversation about the proposed regulatory reform agenda. Ms. Glock is the Director of the Center for Health Care Facility Planning, Licensure and Finance and our Den Mother here, particularly Establishment and Project Review.

Ms. Glock Thank you.

Ms. Glock Good afternoon. I just want to acknowledge that I do have two colleagues that are on Zoom. Patty Robel, who's the Deputy Director for the Center and George Macko, who's the Director of Planning and Licensure, who could not be here today because they are back in the office handling the CON application. Thank you them for participating remotely.

Ms. Glock I'm going to talk a little bit about Certificate of Need regulatory reform. I'm going to get into a few details just to kind of set the table. It might be helpful for new members just to get a couple basic facts. I'll talk about some of the things the department is considering for regulatory reform. My goal is to get some feedback and thoughts from the committee and council on what they might want to see as part of the regulatory reform package. New York's Certificate of Need program. We refer to it as CON. Together with other programs and policies that the department promotes the alignment of health care resources with community health needs. That's our goal. The program should be targeted appropriately at projects that affect access to essential services unnecessarily drive-up costs or raise significant quality or cost effectiveness concerns. I just want to cover quickly the types of projects that require CONs. We've got the establishment or transfer of ownership. Those come to PHHPC for full review by statute. We have what we call all others are construction projects. Those include additions of beds and services, decertification of beds and services, conversion of beds or relocation of facilities, acquisition of major medical equipment and then capital expenditures greater than the minimum cost threshold. The first one is the establishment. They come to PHHPC by statute. PHHPC is the final authority on those. The rest of them are construction applications where PHHPC makes a recommendation to the Commissioner, who has the final authority. Mark covered this a little bit. We look at things like public need, the experience education in the health care interests of the operators, or character and competence on establishment. We look at adequacy of financial resources and the source of those financial resources. We also have a legal review, a program review, an architectural review and a Health Equity Impact Assessment, as you know, which are all part of the review process of these projects from the department. The Governor's 2024

State of the State address said to alleviate strain on both the providers and the state. She charged the Department of Health with making necessary updates to the state's CON program, such as raising the financial thresholds that qualify a project for more detailed review and streamlining the application and approval processes, including, for now, routine services. I'm going to talk a little bit about what are our goals of CON streamlining. We're looking to refine the process to be more responsive to the changing health care environment that we've been talking about. We want to focus both the department and the Public Health and Health Planning Council resources and time on issues and projects that have the greatest impact. Finally, we want to make the process as expeditious as possible within the parameters of this statutory authority. Now, some of that can be done administratively. It's not all a regulatory amendment process. We've started many of those processes back in 2023/2024 to try to figure out where the delays are in the process and to work on those administratively. I'm going to first talk about the project cost thresholds. We're talking about construction only. Establishment applications will not be impacted. If we took a look at the projects that the full review projects that came to the council in 2023 about two thirds of those were establishment projects. The project cost thresholds were last raised back in 2017 as part of the regulatory modernization initiative. We know that construction costs have escalated significantly. I took a look at some Turner Construction Cost Index. If you look at construction costs from 2017 to 2022 it's about a 25% increase. That doesn't account for to 2023/2024. When we raise threshold, we want to be looking proactively into the future. We don't want to be bringing a regulatory package annually.

Ms. Glock I just want to go through quickly what the current cost thresholds are. These are all found in regulation under 710.1. Prior to 2017, there was no ability for non-critical projects. They had to go through review. Back in 2017, we said any non-clinical project with a project cost up to $6 million can be done. Nothing is required at all. We're just talking things about infrastructure, mechanical, electrical upgrades, those types of non-clinical. In 2017, we said, for non-clinical projects greater than $6 million we're going to require a notice. It's not a CON application. It's a notice only. It's limited to non-clinical areas and infrastructure that I currently mentioned. It only applies to Article 28 facilities. There are no architectural documents that are submitted. The required documents are simply a brief project description, appropriate architectural engineer certification for the construction notice. If applicable, a plan to protect patient safety during construction. Construction notices don't have any review units. They only go to the regional office. A pre-opening survey generally is not required, although it could be conducted selectively for certain projects. We are proposing because of the cost escalation in this package. We're considering raising that threshold for notice to $12 million. We're also trying to look at are there certain projects where we could expand the definition of non-clinical? Something that keeps coming up in discussions is an exam room. Something pretty low risk. If an applicant was to convert an office space into an exam room. Could we expand that non-clinical definition to say, it's pretty low risk. Other than a hand-washing sink and a couple of other things that we could see on a drawing. Can we do those types of projects by notice? Notices do not typically result in an operating certificate change. People send notices to the department. We don't really review them, but there's no modified operating certificate involved.

Ms. Glock We go to the limited reviews. Currently, the threshold is $15 million or less for hospitals and for other types of facilities it's $6 million or less. Now, back in 2017, when we raised the threshold we did not raise it for other provider types. We raised it for hospitals only. We are looking at proposing if the cost of construction has raised significantly across all construction projects. We are proposing to raise those for others as well. We would suggest looking at raising that to $30 million for hospitals and $8 million for all others.

Ms. Glock We move into the admins. Currently, projects that are greater than $15 million, but they can't exceed $30 million for hospitals. They can't exceed $15 million for all others. We are proposing raising that, doubling that. We would be raising that up to $60 million. For all others we're proposing raising those construction costs to $20 million.

Ms. Glock I know I'm presenting a lot here. Currently, you can see greater than $30 million. We're proposing raising that to greater than $60 million for hospitals and then raising to $30 million for all others. I'm sorry. $20 million for all others. We're basically looking at doubling for hospitals again. Less than double for all others who have less expensive construction projects typically. What I want to just point out, though, the monetary thresholds alone don't determine the Certificate of Need review level for construction projects. I took a look at projects from 2021 through 2023. If you look at the level of review, things that went full review, less than 20% closer to 10% of a project will go full review based on construction cost alone. That is because under 710.1 10NYCRR Section 710 1. There is a regulation that delineates criteria by which projects are assigned a review level based upon the specific circumstance of the project. The regulatory line outs that say, regardless of project cost if any one of these things are occurring as part of the project the regulation sets what the review level is.

Ms. Glock Absolutely.

Ms. Glock Projects most often have multiple components, right? They're doing a couple of things. There may be parts of the project that could go at a lower level, but then there's something occurring in the project that triggers a full review based under 710. As I said, 710 becomes important. We did not revise 710 according to my understanding back in 2017. We raised the thresholds. We are proposing that we would put forth a regulatory package where we would amend 710.1 and what we really need to think about and what we're looking for feedback on is what types of projects or actions should be subject to what level of review. The three levels just have to go over those quickly. Full reviews they come to PHHPC. All establishment comes to PHHPC. Construction projects that trigger full review come for a recommendation. Administrative review and limited reviews do not require a Public Health and Health Planning Council recommendation. Those are decisions made by the Commissioner. I just want to point out that we collect information on Certificate of Need. All of those factors that I told you we looked at public need, looking at the compliance of the operator, looking at the financial feasibility, what does the demographics of the community look like? We collect that information through something we call schedules. I just want to point out that the schedules from an applicant's viewpoint, the schedules for a full review and administrative review application are identical. The only difference with a full review is now it has to come to PHHPC for the recommendation. It takes a little longer, right? Because we're dependent on the Establishment and Project Review Committee Calendar A limited review is an abbreviated application. There's less schedules involved. It's less burdensome. It's abbreviated. I just wanted to point that out that the schedules between an admin and a full review are the same. As I mentioned earlier, we've got all of the reviews going on. We have architecture. We've got legal. We have program. We have health equity. Sometimes we have the long-term care ombudsman program for nursing home projects. We could have OMH, OASAS. There are a lot of review units assigned to projects. They're not all staff that sit within the Center for Planning, Licensure and Finance. We are the project managers, the coordinators of that project.

Ms. Glock Next slide.

Ms. Glock I just want to point out, because we're talking about project cost thresholds. We're talking about possibly raising them, perhaps doubling them. How do raising those monetary thresholds impact the level of review? How do they impact the Health Equity Impact Assessment requirement for projects? I think it's important to note that under the Public Health Law for the Health Equity Impact Assessment it's really around projects that meet criteria for specific types of transactions. The level of review is not really relevant. Raising the project cost threshold that perhaps could take something from an administrative review to a limited review does not impact the decision as to whether a Health Equity Impact Assessment is required. I think that's important to point out. I want to spend a little bit of time just looking at 710.1. I've tried to illustrate some examples here of projects that come to you as a council and committee members regardless of cost. Any addition of beds comes full review. I think we saw a project last cycle where someone was adding two beds. Do we want all additional beds to continue to go full review? Are there certain categories of beds we are more concerned about? Do we want to consider maybe a percentage? The Health Equity Impact Assessment I believe triggers if you're adding beds it's a 10% threshold. Do we want to consider instead of a single bed or two that, you know, if a certain percentage of the total licensed beds in that category it would become full review. Otherwise, it would be based on the total project cost. Hospital bed conversions to a bed category not already existing in the facility. That could be a bed conversion to a lower level. I think we recently saw an application where a hospital was converting beds to swing beds, alternate level care. That came full review because it's conversion of a bed from one category to another. Another example is addition or decertification or changes in the method of delivery of the following services. This regulation was probably written a long time ago. These types of services were most likely cutting edge, right? They were risky. There were things that we wanted to see full review. We didn't necessarily want them to be set up in every community and over duplication of services. Things like linear accelerators, which they have those in veterinary offices and private physician offices. Bone marrow transplant services. Burn care. Aide centers. Finally, the addition of percutaneous cardiac intervention PCI to a hospital without existing cardiac services. I would ask, are these services that the council would continue to want to see come full review? Have they become now more routine where we could do them at a lower level of review? The second part of my question is are there other more cutting-edge technology that's out there now that we might want to replace these with? Those are the types of things that we're looking at. We are suggesting that these that I've lined out here could possibly be things to go to a lower level. We would be leaving in cardiac surgery lung kidney heart liver transplant. We would be leaving those in as full review. The final example on the slide is the relocation of cardiac catheterization services within a hospital network. We've talked a lot about the changing landscape of health care and the more systems. Do we want those to continue? We're not suggesting that they would not be reviewed by the department. Do they trigger a full level of review if they fall underneath the total project cost. Other reform opportunities. We're looking at eliminating obsolete language. We're looking at projects that we currently fund with statewide health care facility transformation dollars. That's something that we've heard the council mentioned previously. Do we need to bring those projects full review? If the department has had a robust, comprehensive, process to get applications and vet them and determine that there's a need for the projects and is providing funding. My final bullet is things that currently are coming full review under PHHPC policy. They're not required under 710.1. Some examples are extension clinics, hospital and ambulatory center extension clinics. Once someone is established they are able to under 710.1 to establish an extension clinic under the administrative review provided it's under the total project cost. My understanding we've been bringing those full review for the council has expressed interest in seeing

those. Another example is when an ambulatory surgery center converts from a single to a multi-specialty ASC. We're bringing those full review right now. Is there still a desire? Do we still think that a project that there's value and impact and bring them full review? I could go on and on and on, but I think there's a number of questions. I think I'll pause there and see if anyone has any questions or feedback.

Mr. Kraut You teed it up very nicely.

Mr. Kraut Let's start with any questions down here.

Ms. Monroe Are there things we think might go from complete to... I forget your category names now.

Ms. Glock Full and administration.

Ms. Monroe Go from full and administrative if there are things that should go from administrative to full. Are you looking for those ideas as well? Is this a one-way street?

Ms. Glock Hopefully we don't always have one-way streets. I think we've been looking at it in the light of streamlining. Where can we streamline? Where can we make things more efficient? We've started with looking at what's full review that we could do at a lower level. We've looked at things that are limited review. What can we put them into the notice only.

Ms. Monroe Okay.

Ms. Glock However, if there are things that are currently administrative reviews that the council feels under current regulation they'd like to see those at a different level review. Certainly, we'd like to hear that as well.

Ms. Monroe I think that some of these technical ones or the procedural ones, I don't feel the need to see them as much anymore.

Ms. Glock The Lenox, the burn.

Ms. Monroe I mean, I think the market will take care of some of that.

Ms. Monroe I have a question back on your early slide, and maybe I could squeeze that in here. That's Slide 3. Let me just make sure I'm clear. We decide on establishment. When PHHPC decides on establishment that is the final step. Is that correct?

Ms. Glock PHHPC is the final approval on the establishment of operators.

Ms. Monroe On all of the others our role is to recommend.

Ms. Glock That's correct.

Ms. Monroe I would like to know from a continuous learning perspective what the Commissioner does with those things. I don't think we hear at our meetings whether or not he's supported our position or disagrees with our position. I think as part of this whole transparency, and I'm afraid I'm kind of sounding like a broken record but hearing back from decisions we make will help us learn as well. I would like to see put on our agenda responding.

Mr. Kraut Could I just make that just to be clear. What Ms. Monroe was saying, which I think is a wonderful idea is once we act and make a recommendation to the Commissioner, once the Commissioner or the department issues a letter of approval to the applicant---

Ms. Monroe Or declination.

Mr. Kraut Whatever the Commissioner's action are in our next cycle, let's say of meetings we would have a list of the actions that we're taking at the front base assuming they have occurred at the next cycle.

Ms. Glock You're talking about full review only.

Mr. Kraut Well, I think the ones that are in front of us.

Ms. Glock Right.

Mr. Kraut Now, in all fairness, you see everything. All of these things are public. I think it makes a point that Ms. Monroe was saying that that should just close the information loop with us in either way. I think that would be a very... That's easy enough I think. It's not burdensome to do. It's easy enough to do. I think it's a great idea.

Dr. McDonald Can I just follow up on that?

Dr. McDonald Have I overruled them yet on anything?

(Laughing)

Dr. McDonald I think I would have remembered that.

Ms. Glock There's a project that you did put some additional contingencies and conditions on.

Dr. McDonald Is it common for the Commissioner even before me to overrule? I think this is a great idea. By the way, I think you're absolutely right. I think everybody likes feedback. It's part of why I was a pediatrician. I wanted continuity of care. And this looks like continuity of care. I think you're exactly right. How do we know we're aligned? Really, when I spoke this morning I talked a bit about partnership, but if you're heading in one direction, I'm going the other direction. I think you should know that. It's a good idea.

Ms. Glock I just want to add if there are any administrative or limited review applications that you don't see that the Commissioner were to disapprove those have to come back to PHHPC. You will see lower-level projects that are disapproved because they're required by regulation to come to PHHPC for a recommendation.

Ms. Monroe We don't see it or comment on it, but you deny it. We will see it?

Mr. Kraut Yes.

Ms. Monroe Has that happened?

Mr. Kraut No.

Ms. Monroe Okay.

(Laughing)

Mr. Kraut You never know.

Ms. Monroe Well, no that's fine. I just thought that I might have missed it.

Mr. Kraut No, that's fine.

Ms. Monroe I'd like to see some of those technical things come out. Perhaps, community controversy is an issue that should bring stuff forward to us. I don't know how to define it, but where there is significant community opposition or whatever it might be. You said, are there things that we think should come forward? I think perhaps for discussion we should know about those and understand where the department is at. Maybe not formally review them but understand what points of consideration are being discussed.

Mr. Kraut Thank you.

Mr. Kraut Mr. La Rue.

Mr. La Rue Ms. Glock, I support all of your suggestions on raising the thresholds. I have a couple of questions on them. The reason for the higher threshold for a hospital than others is because the underlying entity is worth less.

Ms. Glock I think it has to do with the operating costs. Generally, if you look there's a lower threshold, a higher threshold, and then there's also language in there about that they can't exceed 10% of the operating costs. I think those facilities typically have lower operating costs than the larger hospitals. I know George Mack I was listening in. George, feel free to chime in if you have anything to add. We did not raise all others at all in 2017. We kept them the same. We're recommending that we raise those, but not doubling them. That's something that PHHPC feels that our recommendations too low. We're certainly open to your suggestions.

Mr. La Rue Well, I support your recommended increases. If you want to go further in the other category, please feel free to do so.

(Laughing)

Mr. Kraut Well, I mean, to that point. The historic basis of that was materiality. A $6 million project for a $60 million entity has a different materiality than a $600 million entity. It's a materiality thing on the issue. Is there any consideration so we don't do this once every, five, seven, eight, seven years that you add in an escalator for in cost index inflation? These numbers keep pace with inflation. To some degree they self-correct every year. That might be a consideration once we reestablish those numbers. Pick an index that would be acceptable, some market basket possibly that every year there would be an escalator. That might not be easy to do. When you take a look at the addition of beds and all these things. All of these projects we've never turned down. I mean, that's part of the materiality here. We have never voted against any one of these being approved. We do see it. You're right. Just a couple of beds moving or moving between beds. What we

learned in COVID, a lot of our CON restrictions obviously were suspended. We were able to do amazing things amazingly quickly in response to the emergency. I think the flexibility to use the resources that are available in the entity to respond to whatever momentary changes. This is kind of advocating the application that had just two or three beds. They were filled on one bed unit. They were empty on another bed unit. They weren't decertifying the service, which would require a full review and a HEIA. I'm not talking about that. They're still maintaining it. They just needed to shift over permission to use those beds legally so they can bill. The ability to do that quickly in response to surges and pressures is tremendously beneficial I think. They still have to file the schedules. I would also agree that these are, these are important changes to make and as many of them as reasonable. It's still going to bring us to a fair number of applications that will have obviously all establishments are going to have to come to us. That's where a lot of some of the challenges and some major, the other ones that require a trigger in HEIA, anything over 10% of a bed use that that has to come to us. I think on the on the issues that we should reasonably be concerned and have discussion they'll still come to us.

Ms. Glock Well, just to clarify though, if something triggers for a Health Equity Impact Assessment it doesn't necessarily trigger a full review to come.

Mr. Kraut Well, we still have to do the impact. It's too new of a regulation as much as I think it'll probably need to be looked at a year from now once we have more experience. We just don't have enough experience. It's not worth toying with it yet until we have experience.

Ms. Glock Not to push the point but are their thoughts about like if you add a bed like adding a certain percentage. Are there any bed types that we would want to keep full review? Do we want to say if you're adding 10% or higher of a certain licensed bed category. I'm trying to think how we would write that into regulation.

Dr. Rugge Quick question.

Mr. Kraut Yeah.

Dr. Rugge Just Shelly on that you'd catch it in construction anyway, wouldn't you? I mean, the construction threshold would be exceeded if you're adding 10% or more beds for the most part. That's a different question that I have. The decertification process and a bed and service. I'm just looking at the list requiring CON. Closure plans of a whole hospital. How do those two things interact?

Ms. Glock Currently, for a decertification, which I just happen to have a slide over here. Currently, decertifying beds or services falls under a limited review application according to 710.1. The closure plan requirement on the program side. Although that's a separate process. They come together at the end of the approval. Some things that you're decertifying the beds or services could involve a closure plan as well as the limited review application.

Dr. Rugge Neither would likely come here, right?

Ms. Glock Not currently.

Mr. Kraut Dr. Boufford.

Dr. Boufford I was looking at your slide that talks about the full review requirements. what you just said, which what I was really thinking about here. It's interesting. I was not aware. I thought decertification or reduction of services did come here. it's interesting to me that it doesn't. Because I think we had been really concerned, especially about people closing maternity beds, closing pedes beds, things where they're not making money. I'm surprised at that. Well, I'm also a little bit surprised at some of these. I mean, addition, I don't really a problem. I think the conversion where the facility doesn't already have something in that space implies maybe they aren't prepared to take that service ON. I mean, it seems to me this list is pretty robust other than the additions, but the decertification thing being limited to these items seems to me... I thought decertification was something we looked at because of the loss of services to the public. I don't know when that happened. anyway, I would raise that as my concern about this, I guess.

Mr. La Rue In the case where a hospital submitted a project for $120 million. it was above the threshold you set. $80 million of that was for non-non-clinical stuff, like a parking garage, elevators, things like that. Do you net out and then say, well, it doesn't meet the threshold? It doesn't need a full review.

Ms. Glock I think that's the total project cost submitted by the applicant is what it's considered. It's what they articulate is the total project cost, which plays that into the capital reimbursement piece. It's total project cost. It's usually Article 28 space only.

Mr. Kraut Dr. Kalkut.

Dr. Kalkut About the addition of beds and whether it needs to come here. Have we ever rejected additions of services or additions of beds?

Ms. Glock Not that I'm aware. Rather than just doing internet work transfer, we were encouraging folks to add beds if they needed to.

Mr. Kraut And the point is, in the event of another, we want the hospitals to have as much capacity as they reasonably could staff and take care of and to support that. I think that's not something you want to... It's not in our interest to see a decrease in the bed supply at this juncture.

Dr. Kalkut I would support setting a threshold for like 10% or something like that to add.

Ms. Glock While we're polling the audience can I just throw one other thing out if we've got time?

Ms. Glock Something else I just wanted to get feedback was currently any emergency room renovation or modernization. Regardless of cost, anything to do with the emergency room requires a higher level of review. I'm just wondering. Is that something that EDs that the council's still interested in seeing?

Mr. Kraut First contact. Front door of the hospitals. Critical access. I would argue the quicker they make those changes the better off that community is. If you haven't renovated your ED in several years it's completely undersized for what's occurring there. I know the concern is that you create too much capacity. You should be investing in primary care. We did have those discussions previously, I think. Applicants were asked, well, why aren't you investing in primary care? Not the ED. The issue is that we've been investing in both, but they're coming to the ED still. You have to have that capacity. My perspective.

Mr. Kraut Others?

Dr. Boufford I just wonder if it might, that some of this might have had to do with the levels of trauma center designation relative to the renovation. I don't know. Just a question.

Mr. Kraut It's possible.

Dr. Kalkut I think the growth in the ED volume, certainly Downstate has been rapid and accelerating. I think not having to go through the process makes sense.

Ms. Glock It would just then become dependent on the total project cost and not a specific line item.

Dr. Kalkut Line item increase right size renovation.

Ms. Glock Wouldn't be delineated as having the go higher review, regardless of project cost if we make that change.

Mr. Kraut Ms. Monroe and Dr. Torres.

Mr. Kraut Oh, I'm sorry. Dr. Yang.

Ms. Monroe If we're going to keep full review for things like beds going up and down and whatever, then I think we should have full review for facility closures. I say that for a couple of reasons. One, it provides a forum and independent forum for the parties to make their case. It gives the Commissioner more information for him to make the decision, him or her. I also think it has the potential for a very significant impact in our communities. The idea that we would look at one or two beds moving one way or another, but we're not looking at closures of a facility to me is disproportional to what our purpose and roles should be.

Mr. Kraut Dr. Torres.

Dr. Torres Just wanted to say that for me... You know, many of us represent various communities throughout the state. To hear about these potential changes at a place where we normally wouldn't have that access information helps us. For example, also strategize and understand the further need and the impact to the members of our community. Not that we should be in the way of bottlenecking certain decisions for certain projects, but there's a value to us when you bring it forward.

Mr. Kraut Dr. Yang.

Dr. Yang I think Ann, you just covered my question. I guess the question additionally is since Health Equity Impact Assessments don't apply to do certifications and closures, whether if the department were to consider bringing those into full review. It would make some considerations of impact in that regard.

Mr. Kraut Any other comments? Because I want to take a break.

Mr. Kraut Yes.

Dr. Soffel On the issue of ambulatory surgery centers, I have listened to and participated in a number of conversations about these ambulatory surgery centers that want to go from being a single to a multipurpose. Given Mark's reference earlier to Romer's law. I am curious, and I don't know the answer to this. Is there provider induced demand for ambulatory surgery services that is generating new demand for care that hadn't existed and perhaps is not necessary? I don't know the answer to that. Given the lack of methodology for assessing need for ambulatory surgery services, which we've talked about, I feel uncomfortable saying we should no longer review those applications. My colleagues on the table have said, but this is the way the world is moving. We're moving everything into ambulatory settings. I am still not completely clear on whether that's in consumer interest and meeting consumer need for care. I would say keep those on the review list for now.

Ms. Glock Just a clarification, Dr. Soffel. Are you talking about conversion from single to multi? Are you talking about the establishment of an extension clinic? Because the establishment of an ambulatory surgery center establishment is still going to come full review. We're talking about an established operator who now might want to establish an extension clinic in another location. It's allowed under an administrative review. I'm not sure which scenario.

Dr. Soffel I was thinking about somebody who is currently a podiatry center and wants to become multi-service.

Mr. Kraut It would be establishment.

Dr. Soffel That would then be establishment?

Mr. Kraut Were they're a podiatrist and they want to open up an ambulatory surge center or it's where they're an ambulatory surgery center doing podiatry and they want to open up other procedure?

Dr. Soffel That's what I'm thinking about.

Mr. Kraut She's talking about multi-specialty.

Dr. Soffel It's the same site, not a second site.

Dr. Soffel Same site going from a single specialty to a multi.

Mr. Kraut We've never turned one of those down ever. We've never turned that down ever.

Dr. Soffel We don't have any way of assessing or defining community need for those services either? That's what makes me uncomfortable.

Mr. Kraut Well, we removed the need methodology for ambulatory surgery centers, I believe a decade ago.

Ms. Glock I mean, there's a number of factors that we look at in making the determination, right? We're looking at local demographics. We're looking what other providers are in the area. We're looking at a number of things generally under the general public need regulation. Those are what you see in the exhibit, right? We kind of provide what we feel is

a justification or a need to expand the services in that area. We provide that to you under the public need and program review.

Mr. Kraut What I'd like to do is I'd like to take a fifteen-minute break, come back at a 3:45pm and go for forty-five minutes more. That's it. We're not going to go to five. I think forty-five minutes. In those forty-five minutes I kind of want to recap the day, kind of think a little about what our next steps and agenda were and get a little feedback on how people felt the day was valuable or not, or what might be different, or should we do this again, those kinds of things. I'm going to structure that conversation in fifteen-minute increments just to let you know.

Mr. Kraut Let's take that fifteen-minute break. Please be back in the room by 3:45pm.

Mr. Kraut I'd like to accomplish three things in the next forty-five minutes in fifteen-minute increments if we could do it a little quickly. Kind of working in reverse order here, what we have is the council today, you've heard on regulatory reform, we've heard issues about long term care. We brought up issues, things that we agree with that will probably come back to us as a regulatory package. There are issues we have to follow up on an agenda with character and competence and long-term care. We had an issue. We had a discussion about data and how it's organized and standardized. There were issues we talked about in behavioral care access, substance use, telehealth capabilities, what we heard this morning on the models of care that we saw. There are a lot of topics here that we probably need to kind of refine and come up with possible changes in either our regulations or our processes here. I think the best way to do this, as we followed up from the last retreat and created an agenda is to kind of get a list of items that were discussed and then identify which of our committees might be able to follow up and do a little more work on this. We would structure those committee meetings in such a way to kind of run through the agenda list. It certainly won't be done next week, but within a few weeks what we'll do before the next meeting is get out a kind of a discussion, not a discussion, but a summary of issues that we need to follow up on. We could talk about a process on how to follow them up. As Ann had said, make sure they're on a register that we keep hearing. I'm going to review the day's activities online as well just to make sure. I've taken a lot of notes. There is a second issue that I think we have to kind of focus on that the Commissioner raised. That's regulatory reform. That's not CON streamlining what Shelly talked about. It's about looking at the entire compendium of regulations. He threw a couple of examples up there and used the analogy that we need to prune the health code. We do great add health code. The Codes Committee is always busy. Couple of codes. I don't think we've ever repealed totally any aspect of the code. Sometimes it's repeal and replace, but very rarely is it repeal, and we don't need it anymore. We looked at that many, many years ago. The best way possibly to do that it takes a lot of organization. It's very broad. We probably will have to put together some sort of Ad Hoc Committee that we'd get people to volunteer for and that we'd have to figure out a systematic way with the Department of Health how we should approach this. One of the ways that we approached it last time is basically organizing a process, announcing it, and then asking for comments and feedback of areas we should look at and the rationale. You get a lot of the public, the industry, previous white papers. There were many white papers done after COVID when we repealed so many of the provisions that were considered low value, and then they just expire, the Executive Orders expired. There's a lot of information out there, I think that could inform the process. I do think that needs a very structured process. Some may go into things that deal with public health would go into the Public Health Committee. There are things that might deal with issues that are very clearly planning. I think we need a structure will be productive if we almost organize that as an Ad Hoc Committee. It took us

a year or two last time we did it. It's not one and done. We kind of did it on a rolling basis. I think that's probably the most expedient way to do it. The last thing I just and I want to open up for this kind of fifteen minutes are there other things... I said at the beginning we couldn't possibly touch on everything, right? We didn't really get on public health. You raised some of the issues, all of you that we need to get more into mental health issues and other things. What are the other areas that we should have maybe if we have time on another time and we'll talk about the value of this day and how do we replicate it? Maybe not exactly the same way, but what are the other topics that you think is important for the council to focus on in the future? I just want to open that up to discussion.

Mr. Kraut Yes, Scott.

Mr. La Rue Just make a comment on your previous comment.

Mr. Kraut Oh, sure.

Mr. La Rue If you're going to form an Ad Hoc Committee to review regulations I'm wondering whether it might be somehow organized around program area. I wouldn't do any good sitting there talking about certain things I don't know anything about it, but if you want to talk about regulations related to the things.

Mr. Kraut It would most likely be on programmatic area. Also with the Ad Hoc Committee, we have the ability to appoint people that are not on the council but may be content experts. We can bring other points of view into the room. In addition, you know, obviously you'll have public comment. I think long term care, home care or continuing care, primary care are all important dimensions. I think that's how it would be structured.

Mr. Kraut Dr. Torres.

Dr. Torres I keep thinking about some of the applications that have come before us. Depending on where they are in our state I may not know much about the provider, but something that would speak more on the integration of quality and care.

Mr. Kraut You know, one of the challenges I think everybody has and Scott touched upon it. We have these quality tribes, you know, Leapfrog, U.S. News. There are so many different ones. We don't have single standard definitions that even consumers, anybody can rely on. I guess the CMS, Medicare is the closest where it has a national thing, and even that has limitations sometimes because it only looks at Medicare beneficiaries that are not part of Medicare. They're very thin slices of quality. Again, it has to be looked at, I think functional by industry because it does vary. Let's see what we can look at.

Mr. Kraut Yes, Dr. Boufford.

Dr. Boufford I thought there was at one point in time, having gone to one of the meetings. There is a quality committee. I know if it's in OHIP. I think Marcus was involved. I don't know if it's called quality and safety. I don't believe it's been convened very much or often. It's been sort of dormant. I think that maybe we ought to find out about that. It might be that our raising this issue might get that group activated. It's quite an impressive group of people from all over the state and others. I mean, there are a lot of measures that could be adopted or not. You may be right that we haven't done it, but I think it's been a pretty quiet area. I'm sort of conflating your three fifteen minutes agenda, but I thought of the discussion today it seemed to me that thinking strategically about long-term care,

understanding, as Scott mentioned. I think he's absolutely right about the need for facilities. Raising the question, how could we begin to approach the sort of regardless of site, given that the Master Plan on Aging is going to be asking the state to deal with the fact that people want to stay at home and be with their family and their communities as much as possible. The other issue that was mentioned in passing today is telehealth and telemedicine. I know there were great changes made during COVID. The mental health folks really got way ahead of the curve. I know they were paying as if it was an office visit. There's been a lot of concern about that loosening being repealed. I don't know what the plan is for the medical visit thing or for cross state stuff. I mean, that's a space that I think we probably have something to say about it. We haven't really had a presentation or discussion on it. I guess in the last workforce is something that we talk about all the time. I know the Public Health Committee has said we want to work on the public health workforce. I don't know. We'll see how that goes, but I think... I'm not sure what we can do about it. Again, it may be by raising the questions, bringing people in to talk to us. We could find out who's talking about it and what are they doing. The last time that there was a working group focusing on that was probably ten years ago, I think, really looking at health care and public health. The other two things that I just want to mention. I mean, we have coming up, we have statutory responsibility. We have responsibility for approving the prevention agenda. There are significant proposals to change it very dramatically. They've been discussed in the Public Health Committee and in the Ad Hoc Advisory Committee. Hoping to have a Public Health Committee meeting in June that would answer some of the questions and concerns that have been raised. I'm sorry we didn't have time. We didn't have time to talk about that. I think it's really important to have some time for the whole council. Get the Public Health Committee folks briefed earlier, but there has been set of questions asked, that if they're not answered satisfactorily, I think we should sort of keep them engaged with us to come up with an agreement.

Dr. Boufford It's supposed to be ready for the Public Health Committee June 6th. Sorry, June 5th. It may or may not be ready. I mean, they have the questions. I've been working with public health folks for a while. They had the eight questions, eight or nine questions that were asked during the Public Health Committee. They know they're supposed to be responsive to them. If they're ready, they'll be ready. If they're not ready, then we'll have another round of conversations and we'll have to slip to the next cycle. I think the idea is their guidance doesn't need to come out until September or October, but obviously it would be lateish. It's something that's ongoing. I've had these conversations about well, let me extend the issue on prevention. This is coming up the issue of this group's thinking about the upstream issues. As you pointed out, Scott, there's a large number of older people coming up. They are always going to be people who need residential facilities. The question that's come up in the master plan is, what could we do to promote prevention in older adults earlier in their lives? We don't have to always go back to their prenatal care period, where everybody throws up their hands. I mean, there's really good data now about that. Only about 30% of Medicare beneficiaries ever take advantage of their annual wellness visit, which is free. A lot of the health care facilities aren't organized to do that. Well, we've been learning about that over there. I think there's a lot going on in the aging space and in prevention around aging that's in ambulatory care settings, other specialty settings that we need to start thinking about if we're going to deal with the upstream, the back end, as opposed to only with the services. This has come up a lot. I think we have some oversight on implementation. In a way the master plan is really supposed to be strategic thinking for ten years. The implementation will be left to agencies in the Governor's Office and stuff. The other issue on primary care, I just want to perhaps revisit work that the Planning Committee has done on behavioral, mental health and primary care sort of issues. We've actually had many hearings on those, made recommendations about

how to make that integrated care more effective where possible. Didn't go anywhere maybe. Timing is everything. Maybe it's time to go back and look at that again. We also did a lot of work on some other issues that came up today about whether this sort of the advertising of what really goes on in an urgent care center. What do people have? What does the public have the right to expect? What would be expectations of doctors being placed in pharmacies? We did a lot of talking about that, came up with a set of recommendations and ideas. Hasn't been followed up. As I say, timing is everything. I think those pieces exist in OPCHSM and then could be brought out again into for review. Thanks.

Mr. Kraut I know we can add oral health to that as well.

Dr. Rugge You know, using Howard's presentation as a starting point. Here, we have in the US the most expensive health care and the poorest outcomes among the civilized world and advanced nations. We can't deal with all of that, but we're trying to identify what are the opportunities we have to make a difference. For me, the starting point is how do we put the right patients in the right place with the right providers to get the best outcomes? To do that, we also need to incentivize everybody; hospitals, primary care, everybody has to be incentivized toward that same goal. And for us to keep that in mind and then look for specific recommendations that we can make year by year as a way of trying to be helpful to the people really responsible, which is the Governor and the Health Department and the related agencies. I hope that's all we can aspire to.

Mr. Kraut Any other comments on future agenda?

Mr. Kraut Yes.

Ms. Monroe I want to just pick up on what I think Scott said something about. I would like to just better understand how the department determines financial stability of an applicant. There are all new kinds of funding. There are all new kinds of data. There's stuff I couldn't begin to tell you what it is. I just would like to know when they say to us this is a financially stable organization what have they looked at? I'll just add that, and I've said it before, I really want a system that gives us feedback and closure.

Mr. Kraut Ms. Soto.

Ms. Soto You know, we talk a lot about prevention. Whether it's senior citizen care, whether it's mental health, dental, oral health and all of that. My concern is people having access to this care. What are they doing in terms of health insurance, how available is it the Affordable Care Act, the CHIP, all of that? Some of it is the navigation of it. They are sectors of our population who think they're not eligible. Dr. Boufford just mentioned that senior citizens maybe 40% of benefits that they're entitled to them are not aware of it. What is going on? How can it be more accessible? What information could be disseminated? In some instances, there is the thing about having a navigator in some of the health facilities that people go and help them sign up and what they're eligible for. That's an issue that's on my mind.

Dr. Kalkut It seems that over the past six months there's been a number of DNTC's approved or applications and then approved finances in inner city neighborhoods. I think Peter may have raised it. DNTC potentially becomes an FQHC or certainly could become an FQHC chassis, or they could become a place that sees high volume Medicaid patients and charging through.

Mr. Kraut I mean, Peter, you've heard him say it almost any time. The conversion of private practice into DNTC's for financial viability because they're dependent on patients that are government insured.

Mr. Kraut I love the FQHC model. I'd almost love to remove CON for them just to see them proliferate.

Mr. Kraut Dr. Lim.

Dr. Lim I know we touched on only very briefly here, and I know it's over part of the overall agenda. I think I just want to sort of reemphasize the importance of keeping the waiver, the 1115 waiver as part of not just a formal discussion and report out, but how can this council be an active participant in the discussion and roll out? I mean, we already know about the social care network, but there's multiple components to the waiver. Whatever we can do to really sort of be an active participant in the roll out of that would be great.

Dr. Yang It might be something that Jo has spoken about. I don't know if it was the last retreat in 2017 or the one before that. I think we actually invited the three commissioners of State Health, OMH and OASAS together. It was an incredible moment. I think the question had come up before, I think, when Dan was in your shoes about the coordination or the sharing of information among the agencies on a review for additions or closures or contractions. It'd just be interesting to me to understand what their respective processes are. If there's an administrative, interagency communication, just I know it's not our purview to get into to what they do. It impacts it. If there's a closure of a psychiatric bed or an addition of one, what does that mean for the outpatient service and things like that. Thanks.

Mr. Thomas I just wanted to clarify. On the private practice, the DNTC Center conversions follow up. How should we follow up with the value proposition? I mean, some of us are a little more cynical than others about those conversions and why they're happening. If they're going to happen... The implicit value to the community is that they're now going to be adhering the Department of Health protocols agree to Department of Health oversight.

Mr. Kraut I mean, it's a subset of what Ms. Monroe said is we approve something we'd love to hear like a year from now what happened. Are they active? When did they open? Things like that. I think that that's reasonable. We have three pages of things. I'm skipping lines between each thing. We're going to need to put this down. We need to prioritize some of this. Not some of it. All of it because we have limited resources with the department. Now, some of these are wonderful opportunities for graduate students to do theses, master theses and doctoral dissertations. We'll talk to the department, and we'll figure out a process to do and see what's the highest value that would have the biggest return of items that we are involved in. It's things that come to us or impact us. Because some things, I think are important and the health insurance, the access. We can bring in the facilitated enrollment. We could talk about how uninsured and the pockets and how we're dealing with the undocumented. It's an important issue. I think we can get information, you know, other groups that will come in and inform that. I want to be careful about the department's resources and time. We just have to make sure that we don't create unreasonable expectations of when to get things done. We'll come back and we'll have that discussion to prioritize.

Ms. Monroe Two things.

Mr. Kraut Yes.

Ms. Monroe When you opened today, you said that we need to work in alignment with the department's priorities, right? Could we get a little wallet card with the department's priorities on it?

Mr. Kraut Well, I think that's the whole point of today. As I spoke in preparation with the Commissioner, I think we'll be able to. I mean, he kind of laid it out on one of his slides.

Ms. Monroe Well, you don't have to talk about them now.

Mr. Kraut No, no, no, but I'm just saying they're at a high level. We're trying to make them granular to these issues.

Ms. Monroe Well, I just think it would be a good reminder for us to have this. Just in closing, I told you yesterday that I was going to write down my question and make sure we got to it.

Mr. Kraut Okay.

Ms. Monroe It was about regulatory change. From where I come from, I've been very impressed and pleased with the presentations today and with the opportunity for dialogue, as long as we create a mechanism for continuing that dialogue and accomplishing the things on the list.

Mr. Kraut That gets to the second half of the next fifteen minutes I want to spend is the value of the day. I'm going to assume. I'm going to go out here on a limb here. People found the time useful/valuable.

Dr. Rugge I can speak to that.

Mr. Kraut How would you have changed it in some fashion?

Dr. Rugge I do not want to speak out of turn. Before coming for this last session, I was filling my coffee cup. Who walks but Dr. McDonald, who said he was sorry to have to leave early, but he's got a 7:00 presentation. He was so impressed by the level of engagement and the insights, and the questions delivered by members of this council. Never had the opportunity to see in this kind of context. I take that is an achievement of this council is creating a receptivity in the leadership within government for health care and an opportunity for us to really be both engaged but productive and helpful.

Mr. Kraut Any other feedback on the day?

Mr. Kraut Yes, Dr. Boufford.

Dr. Boufford I mean, I thought it was very good. I think many people have indicated they would have liked to have a little less presentation time and a little more discussion time. I think the question is, how might one consolidate some of your presentations without a lot of... I mean, it was great hearing from all three of the sites, but maybe we didn't need to hear all. Maybe one case example. I'm not saying that was it just that kind of thing. I think people would have liked to have more time to ask questions. What was going on was

having a little bit more this time around. Anyway, I would also say for me. I'll speak for myself. We are the Public Health and Health Planning Council. I found that day and a half very hospital dominated and very facilities oriented. I appreciate that because that's where we spend most of our time. I think part of the idea of creating some time for us to talk is to really be sure those issues get the attention they have. It may well be as we were wishing to streamline regulations and others that there are ways in which we could modify the authority or the responsibility we have for some of these areas that we don't spend as much time on. The last thing I just I need to say, because we started out with Howard, who did a fabulous job. He led off with a slide, which could be misunderstood. The idea is that we spend more on health care than any other country in the world, probably twice as much than most other than Canada. We don't get good health outcomes. The reason for that is we spend 95% of it in the personal health care delivery system, whereas in Europe and others it's $2.00 for every $1.00 spent in health care. It's the broader determinants of health. It's not just social care. It's what are we doing on education, on poverty, on environment, and these other areas that I'm happy to have equal time, some time to present that framework, because I didn't want people to leave with the idea that it's really just all if we fix health care we will get longer longevity and better health. That is not the case. I was concerned. It's Elizabeth Bradley's work. We can send a slide set around, but I think it's...

Mr. Kraut Only about 80 miles away.

Dr. Boufford We don't even have to bring her there. It's in the water now. I think it's this difference between just relative to the waiver. I mean the waiver went in with the word social determinants of health. It came out with social care networks. Very different. I mean, from the clinical side, social care and health care is wrapped around an individual with complex needs to deal with their costs and their needs, and that's great. From a public health side, social determinants are the conditions in the community you're sending them home to. If the air is polluted, if the water is dirty, if they're in lousy housing and they don't have a job, that's the social determinants. We have a limited scope on that. Back to the definitional question, we really need to get that clear and our own thinking, because we may have a broader stage to play on if we think about it that way.

Mr. Kraut The fact that you're all five still here bodes well for the future.

(Laughing)

Mr. Kraut It's the next visit we'll have to worry about what we see do the work. We really appreciate that you made the effort to come here and to join us. We assume and hope your people are nominated. You've been nominated. We just want to see you get approved. I think it's a good kind of introduction to the range of topics. You can appreciate how intellectually interesting your time will be here. You'll find other time that'll be tedious, but if you have any comments.

Mr. Kraut Yes.

Mr. Kraut Stanford.

Mr. Perry Thank you, Jeff. I found today and yesterday to be very interesting and delighted to be a part of what's happening here. One thing that I've noticed throughout all of the presentations and discussion is that the word disability isn't mentioned once. I think it's very important that we begin to look at health care policy and how it affects the class of

people who are the most disengaged and disconnected from those policies, and what we can do to change policy to ensure that we provide services in an integrated fashion to a population that is, I would say, the neediest in New York State, especially when you look at DOH licensed intermediate care facilities that provide daily 24 hour support to people who are extremely behaviorally as well as medically challenged in many different ways to ensure their full access and the improvement in terms of their heedless measures as well.

Mr. Kraut I appreciate that. We talk about the O agencies. I don't think we ever really say OPWDD. I think your presence on the council will help raise our awareness and understanding. As I'm well aware, you've addressed a lot of the health care needs by creating an FQHC on your campus specifically devoted to that population and serving their needs.

Mr. Perry Thank you.

Dr. Perry There were many policies, COVID related policies that were very helpful to FQHCs and serving people with disabilities who rely very heavily on staff to transport them, staff to really meet their basic day to day needs. Once those COVID provisions changes, the threshold rules, for instance, that a psychiatrist or psychologist needed to be at the facility. These folks were accustomed to working from home and being able to engage in telemedicine. As a result, the difficulty and the challenge in treating people with severe behavioral needs has been severely impacted. Number one, the staff to get them there. Number two, the licensed professional who's accustomed to working from home now and doesn't want to come to the FQHC as they did not have to do the entire time they were under those COVID rates.

Mr. Kraut Again, we did this last time in 2017. I mean, the follow up will be more meaningful. We can come back to this discussion. I think that a day of these kind of discussions a little more tailored to specific topics is beneficial for us to do at least once a year, if not twice a year. I just as a practical matter knowing how challenging it was for our staff to do an overnight, how would people feel if we identified... You know, we still have to do committee days. We have to do meetings. It's very hard to do a three/four-hour session on a day we're doing a three/four-hour thing. I think our minds, you know, particularly some of our meetings just you're exhausted mentally, I think after that both committee meetings and full council meetings. If we were to as we develop the calendar to pick a date in the Spring or maybe Spring and Fall where we would identify not an overnight necessarily, but a day which would start at 10:00am and end at 4:00pm and we would each year or maybe each six months have an educational session that adds an extra burden to you. I would at least try to do one more maybe. Would people be willing and see that valuable to do that? Anybody doesn't think it's too much of a burden? I just don't think we could go to the expense and logistics of sleeping over and we would just do it in a central location.

Dr. Kalkut I don't think that's really necessary, Jeff.

Mr. Kraut Maybe what we'll try to do is see if we could slot it in on the calendar. It also would have a kind of a feedback loop where we would report on things we did in the previous meeting and the follow up. There's some accountability. We'll try to also work that into our meetings as Ann had suggested as well. There's certain feedback we could just do automatically. That's about it.

Dr. Boufford One other just logistical. I think you had mentioned this, but I just raise it again in the thinking people might have. You all have done a lot to try to streamline the

agenda for the PHHPC meetings with sort of grouping and stuff is maybe just... I think we've been tending to leave around 1:00pm or 2:00pm and whether there's just an hour that might be sort of a discussion, educational hour. People could stay if they can or if they leave if they don't. It would be a way to get smaller doses of the kinds of issues we want to talk about, and people could choose to take advantage of, but we would have done our business. That part would be over.

Mr. Kraut At the conclusion of the full council, there would be a presentation of a topic, probably for discussion. Those who could stay could stay. We'll look at the train schedules and the plane schedules and see how we can do that. That's a good idea. I mean, it's worth to try it and do that.

Dr. Torres You know, in listening to some of the comments here today and yesterday, how wonderful it would be for us to have some level of engagement and exposure to Senate, Assembly and Council. We have these discussions with our elected officials. Educating them on the impact of that landscape, of the health landscape, what it means to their constituents. It would be nice to see if there's an ability to include them.

Mr. Kraut That's something I will talk to the department. You can invite the heads of the committees here or they can invite us to them. It's probably more dangerous.

(Laughing)

Dr. Kalkut Just quickly, the sessions called education. I don't know what the content was in there, and the and content was, about our own processes, which I thought was really helpful and to go through some of the issues that we act on or create lanes for us to act on every meeting. Why are we doing it the way we're doing it? Where is that discussion?

Mr. Kraut I think we can go look at our processes. We didn't get too deep into that about how we take public testimony, whether we should require more written testimony. I think part of that Ad Hoc group that might look at regulation might also look at our own processes, bylaws and whatever as well.

Ms. Monroe Thank you for putting this together.

Mr. Kraut I wanted to end where we began, and I wanted to first thank the members for committing the time and effort and encouraging this to happen. I want to thank our hopefully new members for joining us. I particularly want to thank the department, the staff that everybody who worked on this to make this a reality. It's not easy. You just think they wrote these slides. The level of review and approval to get them into this room, as you'd expect is at times challenging. At times it's easy, but very rarely. Colleen, Michael, Jacob, you guys are just amazing.

(Clapping)

Mr. Kraut We cannot thank you enough as we repeatedly say at almost every meeting. I'm so glad.

Mr. Kraut Yes, Ms. Soto.

Ms. Soto Is there a way to coordinate those of us that have to get to the Tarrytown Train Station? Because there's quite a number of us.

Mr. Kraut We'll figure it out. Just get out there and somebody use you Uber and then take everybody with you.

Mr. Kraut I thank members of the public who have joined us and stayed through it both online and in person. Thank you very much. Thank you for the time. We are adjourned.